CONTRACT FOR SERVICES

Between

the

State of Nebraska

Nebraska Department of Health and Human Services Finance and Support

and

Exclusive Healthcare, Inc.

A Health Maintenance Organization in the Nebraska Medicaid Managed Care Program

June 25, 1999

ARTICLE I

1.0 INTRODUCTION

The Nebraska Department of Health and Human Services Finance and Support, hereafter considered the contracting agency and referred to as the Department, and Exclusive Healthcare, Inc., hereafter considered the contractor and referred to as the plan, a Health Maintenance Organization (HMO) with a certificate of authority to do business in Nebraska, an organization which makes available to a client participating in the Nebraska Medicaid Managed Care Program (NMMCP), hereafter referred to as the Nebraska Health Connection or NHC, who is enrolled with the HMO, in consideration of a fixed monthly capitation payment, comprehensive health care services, hereafter referred to as the Basic Benefits Package, by providers who are employees and partners of the plan or who have entered into a referral or contractual arrangement with the plan, and in the case of the Primary Care Physician, hereafter referred to as the PCP, who provides the client a "medical home".

The Nebraska Health Connection (NHC), which is the Nebraska Medicaid Managed Care Program (NMMCP) under the Nebraska Medical Assistance Program (NMAP) approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act and which is operated under the federal authority of the Medicaid program, Title XIX of the Social Security Act and which certain requirements of the Social Security Act have been waived by the federal government on the Department's request under section 1915(b) of the Act and which elements include statewideness (under 1902(a)(1) of the Act); comparability of services (under 1902(a)(10)(B) of the Act); freedom of choice (under 1902(a)(23) of the Act); Section 1915(b)(2) of the Act that allows a central broker to assist clients in choosing among health plans and Section 1915(b)(4) to require clients to obtain services only from specified providers under the NHC; and under the State authority of the Managed Care Plan Act, codified as sections 68-1048 through 68-1066, and sections 68-1030 and 68-1031, R.R.S., 1943, which directed the Department to develop a managed care program for the purposes of improving the health and wellness of the Nebraska Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State, and offering clients expanded choices, increasing access to primary care, greater coordination and continuity of care, cost effective quality health services, and better health outcomes through effective care management.

The above reference to the pertinent federal regulations may not be an exhaustive list. Any provision of the program which is in conflict with federal Medicaid statutes, regulations, or other Health Care Financing Administration (HCFA) policy guidance will be amended to conform to the provisions of these laws, regulations and federal policy. Such changes will be effective on the effective date of the statutes or regulations necessitating them, and will be binding on the parties even though such changes, and subsequent amendments to the contract, may not have been reduced to writing and formally agreed upon and executed by the parties.

The Department shall notify the plan of substantive changes in the Medicaid program that affects the NHC. Appropriate contract amendments will be made unless the plan determines that such changes will result in a materially different obligation or renumeration for the services to be performed. In that event the Plan may terminate the contract upon 60 days notice as provided in Article VIII. In the interim, any contract amendment would not become effective.

ARTICLE II

2.0 OBJECTIVE AND SCOPE

***2.1 Objective**:* The objective of this contract is to formally define the responsibilities of the contractor as an HMO, in providing the Basic Benefits Package for the NHC in the designated coverage area, pursuant to this contract. The Basic Benefits Package (i.e., medical/surgical services) for the NHC is provided through two managed care models:

(a) One or more Health Maintenance Organizations (HMO); and

(b) One Primary Care Case Management (PCCM) Network.

While both models comprise a single managed care program, each is written as a separate contract to facilitate the contractor's understanding of specific programmatic requirements.

***2.2 Scope**:* The Department does not anticipate a limit on the number of contracts that it will offer to any qualifying plan under the NHC. The Department maintains the authority to choose which plan(s) it will enter into a contractual relationship with.

A client who is already participating in the NHC and who is enrolled with a plan shall remain with that plan if the Department continues a contractual relationship with that plan and that is the client's choice. A plan that is new to the NHC and who enters into a new contractual relationship with the Department shall become available for enrollment effective July, 1999.

The Department shall not "systematically" redistribute any clients who have already established a " Medical home" with a PCP and plan as a result of a new plan contracting with the Department.

If any of the plans that the Department currently contracts with are not offered a continuing contract, the Department shall afford the client the right to transfer to any of the available plans effective July, 1999.

Contracting with all qualifying plans shall afford the client a greater choice of PCP and/or plan. A client is free to choose a PCP from any of the plans participating in the NHC as HMOs, or from the Primary Care Case Management Network, hereafter referred to as the PCCM Network.

Under the provisions for auto-assignment, the Department shall attempt (based on the auto-assignment algorithm) but shall not guarantee a fair distribution of clients to the available plans. The Department will not change the auto-assignment process without first discussing such changes with plans.

ARTICLE III

3.0 STATE ORGANIZATION AND BACKGROUND

***3.1 State Organization**:* The State of Nebraska currently provides health care coverage through the Nebraska Medical Assistance Program (NMAP) for over 153,000 individuals per month at an annual cost of approximately $700,000,000. The Department is the state entity designated to administer the NMAP and the NHC, pursuant to state and federal regulations.

3.2 Background: In 1993, State legislation was passed which directed the Department to develop a managed care program. Managed care in Nebraska was implemented in July, 1995.

The NHC consists of the following program components:

(a) NHC Benefits Package

(1) Basic Benefits Package, and

(2) Mental Health and Substance Abuse (MH/SA) Package;

(b) Enrollment Broker Services; and

(c) Data Management Services.

The Basic Benefits Package was implemented on July 1, 1995 in the designated coverage areas. The Mental Health/Substance Abuse (MH/SA) Package was implemented on a statewide basis on July 17, 1995.

From July, 1995 through July, 1999, the NHC has utilized one PCCM Network and two HMOs for delivery of the Basic Benefits Package. A Prepaid HealthPlan (PHP) has been utilized for the delivery of the MH/SA Package, as a "carve-out" from the Basic Benefits Package.

Enrollment into NHC shall be mandatory for specified clients. During enrollment, the client shall choose a Primary Care Physician (PCP)/plan for the Basic Benefits Package in the designated coverage areas, ensuring the client a "Medical home". In the designated coverage areas, the client's enrollment is facilitated by the Enrollment Broker Services (EBS). Enrollment in the areas of the State where managed care only includes the Mental Health and Substance Abuse Services, hereafter referred to as MH/SA services, is "automatic", i.e., the client is not required to make a choice of PCP/plan, but is required to access MH/SA services through the contracted plan for MH/SA services.

The Integrated Health Organization (IHO) development in the Western, Southeast and Central Service Areas of Nebraska is the Department's pilot effort to expand managed care to greater Nebraska, but is not part of this contract. The ultimate goal of the Department is to develop various models of managed care throughout the State as areas become ready.

The MH/SA services component of the NHC shall continue to be provided on a statewide basis as a " Carve-out" from the Basic Benefits Package. The provision of MH/SA services is not part of this contract, except as specifically addressed.

The Enrollment Broker Services, hereafter referred to as the EBS, and the Data Management Services, hereafter referred to as the Medstat Group, shall be continued under current contractual arrangements.

The IHO development, implementation dates and any relationship or similarities that may exist between the IHO and the NHC program is not yet known, but shall be made available to the plan as the Department moves forward with this initiative.

ARTICLE IV

4.0 Definitions

4.1 Applicable Definitions: The following definitions apply under this contract:

4.1.1 The term **" ADA"** means Americans with Disabilities Act of 1990 as amended, 42 U.S.C. 12101 et seq.

4.1.2 The term **" Auto-Assignment"** means the process by which a client, who does not select a Primary Care Physician (PCP) and plan within a predetermined length of time during enrollment activities, is automatically assigned to a PCP/plan. Commonly referred to as **" Assignment" or " Default Assignment" .**

4.1.3 The term "**Basic Benefits Package",** means the following medical/surgical services, representing a minimum benefits package, as defined in this contract and 471 Nebraska Administrative Code (NAC), that shall be provided by the plan to clients enrolled in the NHC:

(a) Inpatient hospital services (See 471 NAC 10-000);

(b) Outpatient hospital services (See 471 NAC 10-000);

(c) Clinical and anatomical laboratory services, excluding laboratory services related to Mental Health/Substance Abuse (MH/SA) effective January 1, 2000 (See 471 NAC 10-000 and 18-000);

(d) Radiology services, excluding radiology and anethesiology services related to MH/SA effective January 1, 2000 (See 471 NAC 10-000 and 18-000);

(e) HEALTH CHECK (Early Periodic Screening and Diagnosis and Treatment as federally mandated) services (See 471 NAC 33-000 and Section 13.42 of this contract);

(f) Physician services, including nurse practitioner services, certified nurse midwife services, and physician assistant services, anesthesia services including a Certified Registered Nurse Anesthetist, excluding anesthesia for MH/SA (See 471 NAC 18-000 and 29-000);

(g) Home health agency services (See 471 NAC 14-000). (This does not include non-home health agency approved Personal Care Aide Services under 471 NAC 15-000);

(h) Private duty nursing services (See 471 NAC 13-000);

(i) Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology. (See 471 NAC 17-000, 22-000 and 23-000);

(j) Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (See 471 NAC 7-000 and 8-000);

(k) Podiatry services (See 471 NAC 19-000);

(l) Chiropractic services (See 471 NAC 5-000);

(m) Ambulance services (See 471 NAC 4-000);

(n) Medical transportation services (See 471 NAC 27-000);

(o) Visual services (See 471 NAC 24-000);

(p) Family Planning services (See 471 NAC 18-000 and Section 13.47 of this contract);

(q) Emergency services (See 471 NAC 10-000 and Section 13.8 of this contract);

(r) Transitional MH/SA services (See 471 NAC 20-000 and 32-000 and Section 13.49 of this contract);

(s) Federally Quality Health Center (FQHC), Rural Health or Tribal Clinic services (See 471 NAC 11-000, 29-000, 34-000 and Section 13.50 of this contract);

(t) Certified Nurse Midwife services (See 471 NAC 18-000 and Section 13.51 of this contract);

(u) Skilled/Rehabilitative and Transitional Nursing Facility services (See 471 NAC 12-000, 13-000 and Section 9.20 of this contract);

(v) Transitional Hospitalization services (See 471 NAC 10-000, Section 9.13, 9.17, 9.18, and 9.19 of this contract); and

(w) Transitional Transplantation services (See 471 NAC 10-000 and Section 9.18 of this contract).

4.1.4 The term **" Capitation Fee"** means the fee paid, by the Department to a Health Maintenance Organization (HMO), on a monthly basis for each client enrolled with the plan. The fee covers all services required to be provided by the HMO to the client, regardless of whether the client receives services or not.

4.1.5 The term **"Carve Out"** means to indicate that the mental health and substance abuse package is separated or "carved-out" from the Basic Benefits Package for ease of administration, contracting and federal waiver approval. The Nebraska Health Connection is still considered one program, encompassing both components.

4.1.6 The term **"Choice"** means the client is free to choose a Primary Care Physician (PCP) and plan from all available options within the NHC.

4.1.7 The term **"Client"** means any individual entitled to benefits, under Title XIX of the Social Security Act and under the Nebraska Medical Assistance Program (NMAP) as defined in the Nebraska Administrative Code, hereafter referred to as NAC.

4.1.8 The term **"Contract"** means the legal and binding agreement between the Department and the plan.

4.1.9 The term **" Contract Year"** means the fiscal year commencing on the effective date of the Contract.

4.1.10 The term **" Covered Services"** means the Basic Benefits Package of services provided under this Contract, pursuant to the Nebraska Administrative Code.

4.1.11 The term **" cutoff"** means 5:00 p.m. Central Standard/Daylight Time on the fourth working night before the end of the month. Data must be entered on the Department's computer system by this deadline in order for changes to be effective the first of the month.

4.1.12 The term **" Designated Coverage Area~~s~~"** means areas of the State in which clients are considered mandatory for participation in the NHC. For purposes of the Basic Benefits Package, the designated coverage areas shall include those mandatory clients whose eligibility assistance case is managed by the Health and Human Services (HHS) Office, primarily in the Douglas and Sarpy Counties in the Eastern HHS District Office (commonly referred to as District 8), and in the Southeastern District Office, primarily in Lancaster County (commonly referred to as District 7).

4.1.13 The term **" Designated Specialty Care Physician"** means a specialty care physician who has enhanced functions for clients with special health care needs designated, upon review and concurrence, by the Primary Care Physician (PCP), the specialist and the plan. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc.

4.1.14 The term **" disenrollment"** means removal of a client from the NHC.

4.1.15 The term **" Emergency Services"** means covered inpatient and outpatient services that are furnished by a qualified Medicaid provider and are needed to evaluate or stabilize an emergency medical condition.

4.1.16 The term **" Emergency Medical Condition"** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(b) Serious impairment to such person's bodily functions;

(c) Serious impairment of any bodily organ or part of such person; or

(d) Serious disfigurement of such person.

4.1.17 The term **" Encounter Data"** means detailed claims information submitted by the plan representing all services rendered to a client.

4.1.18 The term **" Enrollment"** means completion by the client of all requirements of the enrollment process in the designated coverage areas, including receiving information on managed care; completing the health assessment; and selecting a Primary Care Physician (PCP) /plan. In some cases, if a client does not complete enrollment, s/he is automatically " assigned" to a PCP/plan.

4.1.19 The term **" Enrollment Broker Services (EBS)"** means a contracted entity that is responsible for the following NHC functions: initial client marketing, education, and outreach; enrollment activities; health assessments; health services coordination; public health nursing: Helpline; client advocacy; and EBS satisfaction surveys.

4.1.20 The term **" Enrollment Month"** means the month of enrollment for a client that is effective the first of a month through the end of the month.

4.1.21 The term **" Enrollment Report"** means a data file provided by the Department to the plan that lists all clients enrolled in the plan and disenrolled for the enrollment month. The enrollment report is used as the basis for the monthly capitation payments.

4.1.22 The term **" Family Planning Services"** means services to prevent or delay pregnancy, including counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. This includes tubal ligations and vasectomies. Treatment for sexually transmitted diseases (STD) pursuant to this contract shall be reimbursed by the plans in the same manner as family planning services, without referral or authorizations by the Primary Care Physician(PCP)/plan. This shall not include hysterectomies or other procedures performed for a medical reason, such as removal of an intrauterine device due to infection, or abortions. See Addendum A.

4.1.23 The term **" Fee-for-Service"** means payment of a fee by the Nebraska Medical Assistance Program (NMAP) for each service provided to a client who is not enrolled in the NHC, or who is enrolled in the NHC but who meets certain programmatic exceptions.

4.1.24 The term **" Fiscal Year"** means the period used by the Department for accounting purposes, which begins July 1 and ends June 30 of the following calendar year.

4.1.25 The term **" HCFA"** means the Health Care Financing Administration, a division within the federal Department of Health and Human Services.

4.1.26 The term **" HHS"** means the Department of Health and Human Services. Specifically, for this contract, the Department of Health and Human Services Finance and Support, referred to as the Department.

4.1.27 The term **" Health Maintenance Organization (HMO)"** means an HMO with a Certificate of Authority (COA) to do business in Nebraska that has contracted with the Department under the NHC.

4.1.28 The term **" Interim PCP"** means a Primary Care Physician (PCP) designated by the plan when the client's chosen or assigned PCP is not available, and shall only be applicable until the client requests a different PCP. The duration of an " interim PCP" is only until a subsequent change is activated, effective with the first month possible given system cutoff.

4.1.29 The term **" Integrated Health Organization (IHO)"** means a formal arrangement of existing organizations, legally bound by contract, merger, or other type of arrangement, composed of various health care providers with membership possibly extending to human service professionals and/or insurers. Each existing organization within the network dedicates resources, and carries out collaborative functions and services according to a specified plan of action. The IHO may be a risk-based or fee-for-service model, and may provide the Basic Benefits Package and/or the Mental Health/Substance Abuse (MH/SA) Package of services.

4.1.30 The term **" Lock-In"** means a method used by the Department to limit the medical services of a client who has been determined to be abusing or overutilizing services provided by the Nebraska Medical Assistance Program (NMAP) without infringing on the client's choice of a provider.

4.1.31 The term **" Managed Care File"** means the Department's automated file, containing client and provider information, created to support the NHC.

4.1.32 The term **" Medical Necessity",** means health care services and supplies which are medically appropriate and (1) necessary to meet the basic health needs of the Client; (2) rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Covered Services; (3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health coverage organizations or governmental agencies; (4) consistent with the diagnosis of the condition; (5) required for reasons other than the convenience of the Client or his or her Physician; (6) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; (7) of demonstrated value; and (8) a no more intense level of services than can be safely provided. The fact that the Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean that it is Medically

Necessary. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

4.1.33 The term **" Mental Health/Substance Abuse (MH/SA) Network"** means the network of MH/SA providers that constitutes the MH/SA services component of the NMAP, and is addressed under a separate contractual arrangement.

4.1.34 The term **"NAC"** means the Nebraska Administrative Code

4.1.35 The term "**NHC"** means the Nebraska Health Connection.

4.1.36 The term **" NMAP"** means the Nebraska Medical Assistance Program, administered by the Department of Health and Human Services-Finance and Support Division, and is commonly referred to as **" Medicaid" .**

4.1.37 The term **" NMES"** means the Nebraska Medicaid Eligibility System, which is an automated eligibility verification system for use by Medicaid providers.

4.1.38 The term **" Per Member Per Month (PMPM)"** means the basis of payment for a Health Maintenance Organization (HMO) capitated rate, the Primary Care Case Management Network (PCCM) administrative fee, and the Primary Care Physician (PCP) case management fee in the PCCM Network.

4.1.39 The term **" Physician Extender"** means a nurse practitioner, physician assistant, certified nurse midwife, or second-year and third-year resident who meet the requirements for practicing in Nebraska, who is enrolled in the Nebraska Medical Assistance Program (NMAP), and who is identified as such on the Provider File. The Physician Extender is not designated as a Primary Care Physician (PCP) but increases the number of clients to whom the PCP may provide a medical home.

4.1.40 The term **" plan"** means a generic term used to reference any of the healthplans participating in the procurement, contracting or programmatic aspects of the NHC. For the purposes of this contract, this is a healthcare entity that meets the definition of a Health Maintenance Organization (HMO) and provides the Basic Benefits Package.

4.1.41 The term **" Primary Care Case Management (PCCM) Network"** means a network of contracted Primary Care Physicians (PCPs) who provide the Basic Benefits Package to NHC clients. Services provided through the PCCM Network are reimbursed on a fee-for-service basis by the Department. The PCCM Network is a non-risked-based managed care model. The Department contracts with a PCCM Network Administrator who is responsible for the development, oversight and operation of the PCCM Network and all related PCCM Network administrative services under a separate contractual arrangement. The PCCM Network and Network Administrator is not part of this contract, but is addressed under a separate contract.

4.1.42 The term **" Primary Care Physician (PCP)"** means a plan credentialled physician chosen by the client or assigned by the Department who provides a " medical home" for the client and whose primary expertise is in family

practice, pediatrics, general practice, internal medicine, or obstetrics/gynecology. A PCP may participate in the NHC with any of the contracting plans. The PCP shall be a Medicaid-enrolled provider.

4.1.43 The term **" PRO"** means the Peer Review Organization under contract with the Department to perform specified level of care determinations.

4.1.44 The term **" Proposal"** means the written document submitted by the plan in response to the Request for Proposal, which preceded this contract.

4.1.45 The term **" Provider Agreement"** means any written agreement between the plan and a provider, or between the provider and the Department, for the purpose of enrolling as a Medicaid provider.

4.1.46 The term **" Request for Proposal (RFP)"** means a document written by the Department for the purpose of procurement for contractual services for the NHC.

4.1.47 The term **" slots"** means a designated number of clients for whom a Primary Care Physician (PCP) provides a " medical home" under the NHC.

4.1.48 The term **" subcontract"** means any written agreement between the plan and another party to fulfill the requirements of this contract except Provider Agreements as defined above.

4.1.49 The term **" Third Party Liability (TPL)"** means any individual, entity, or program that is, or may be, liable to pay all or part of the cost of medical services furnished to a client.

4.1.50 The term **" Transfer"** means a change in a client's enrollment or assignment from one Primary Care Physician (PCP) to another PCP, or from one plan to another.

4.1.51 The term **" Waiver of Enrollment"** means a process by which a mandatory client is not required to participate in the NHC, on a case-by-case exception basis.

4.2 Other Applicable Terms: Terms that are not defined above shall have their primary meaning identified in the Code of Federal Regulations (CFR), Nebraska Administrative Code (NAC), directives issued by the Department, and plain and ordinary meanings.

5.0 GENERAL PROCUREMENT

The Department represents that it has complied with all state and federal requirements in identifying expectations of the plan, in issuing the RFP dated December 4, 1998, and in procuring this contract.

6.0 CONTRACT

6.1 Contract Period: This contract shall be written for a period of two years effective July 1, 1999 through June 30, 2001, with the option for two two-year renewals (2+2+2) as mutually agreed upon by the parties.

6.2 Authority to Extend Existing Contract: The Department retains the authority to extend an existing contract in situations where negotiations for a new contract are not completed by the expiration date of the contract. Renegotiation and modification of the contract shall occur under the Department's discretion in the event that the terms of the contract require substantial change in the functions and/or requirements of the contractor.

6.3 Contract Amendment: Any provision of the program which is in conflict with federal Medicaid statutes, regulations, or other Health Care Financing Administration (HCFA) policy guidance shall be amended to conform to the provisions of these laws, regulations and federal policy. Such changes will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such changes, and subsequent amendments to the contract, may not have been reduced to writing and formally agreed upon and executed by the parties.

The Department shall notify the contractor of substantive changes in the Medicaid program that affects the NHC. Appropriate contract amendments shall be made unless the plan determines that such changes will result in a materially different obligation or renumeration for the services to be performed. In that event the plan may terminate the contract upon 60 days notice as provided in Article VIII. In the interim, any contract amendment would not become effective.

ARTICLE VII

7.0 DELEGATIONS OF AUTHORITY

No delegations of any authority vested in the Department are permitted under this contract.

ARTICLE VIII

8.0 PLAN AND DEPARTMENT RESPONSIBILITIES - GENERAL CONTRACT REQUIREMENTS

8.1 Deliverables: All deliverables shall be approved by the Department in order for them to be considered complete. "Deliverables" are defined, for purposes of this contract, as all mandatory activities required by the terms of this contract to be furnished by the plan to the Department. The Department shall not unreasonably withhold said approval.

The format and content of each deliverable shall be defined and agreed upon in detail prior to its submission. The Department shall not review any deliverables unless the format and content have been approved.

The plan shall define the format and content of each deliverable. The plan shall provide the Department with an outline, sample format, draft description, proposed schedule and approach for producing the deliverable. The Department shall review and approve the outline, format, description, schedule and approach. Deliverables shall become a basis for measuring plan performance as defined in the contract between the Department and the plan. The plan shall be required to work cooperatively with the Department to develop and implement all deliverables. The plan shall be required to begin the development of these deliverables immediately following the completion of contract negotiations. The plan shall make changes to its deliverables as requested by the Department but the Department represents it will request only reasonable and necessary changes after consultation with the plan.

Each deliverable produced by the plan shall be reviewed by the Department. The review process shall ensure compliance with the agreed upon plan and content of the deliverable, and within the terms of the contract. Based on the review and findings, the Department may grant approval, reject portions of or the entire document, or request that revisions be made by the plan. The State will complete its review of the deliverable and notify the Plan of any deficiencies in the document within 30 days after receipt or it will be deemed approved. Additional review periods shall be required whenever revisions are requested or a deliverable is rejected. Each deliverable shall be complete within and of itself, and shall be consistent with any previous deliverables produced, unless the format has been changed as required or approved by the Department.

Deliverables are discussed throughout this contract. The plan's proposal submitted in response to the RFP shall become part of the framework for the ongoing development and implementation of the NHC, in conjunction with other documents identified in 8.2 of this contract. The Department shall maintain authority for the overall development and implementation of the NHC, but develop the contract and subsequent documents in such a manner as to assist the plan in developing its organizational strategy for participating in the NHC program.

8.2 Applicable Documents: The contract shall incorporate the following documents:

(a) Any contract clarification or amendment, in order of significance;

(b) The plan's proposal;

(c) Any RFP addenda, including any questions/answers;

(d) The signed RFP Form; and

(e) Pertinent State and Federal regulations.

All modifications and/or changes to any provision must be agreed to in writing by the Department, and the contractor, and must be incorporated as a written amendment to the contract.

8.3 Compliance With Civil Rights Laws and Equal Opportunity Employment: The plan shall assure the Department that it shall comply with the Nebraska Fair Employment Practice Act and Title VI of the Civil Rights Act of 1964, as amended so that no person shall, on the grounds of age, creed, sex, physical handicap, race or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under the contract, program or activity supported by the contract.

The Federal Rehabilitation Act of 1973, as amended, the Americans With Disabilities Act of 1990 (P.L. 101-336), as amended, Section 5043 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, as amended, and the Nebraska Fair Employment Act, as amended are incorporated herein.

The plan further agrees to include similar provisions in all subcontracts for services allowed in connection with this contract, for services which are entered into following this contract.

The plan will comply with the Nebraska Fair Employment Practice Act.

8.4 Clean Air and Water Acts: The plan shall comply with all applicable standards, orders and requirements issued pursuant to Section 306 of the Clean Air Act (42 U.S.C. 1857 (H), Section 508 of the Clean water Act (33 U.S.C. 1368), Executive Order 11738, Environmental Protection Agency regulations (40 CFR Part 15) and applicable requirements of OMB Circular A-102.

8.5 Ownership Of Information, Software and Data: Unless otherwise prohibited by law or confidentiality requirements, the Department shall have the unlimited right to publish, duplicate, use and disclose all information and data developed or derived by the plan to the extent such data is required by those contracts to be furnished to the Department.

The plan must guarantee that it has the legal right to use materials, supplies, equipment and software necessary to execute the requirements of this contract. It will be the responsibility of the plan to pay for all royalties and costs, and the Department shall be heldharmless from any claims of infringement for use of information and data in accordance with the terms of this contract.

8.6 Permits and Regulations: The plan shall procure and pay for all permits, licenses and approvals necessary for the execution of the contract. The plan shall comply with all laws, ordinances, rules, orders and regulations related to the performance of the contract.

8.7 Cooperation With Other Plans: The Department intends to award a contract to more than one plan for work related to the NHC. This decision shall be made by the Department, based upon the cost and quality of the proposal submitted by the plan. The Department reserves the right to award as many contracts as it deems appropriate. The plan shall agree

to cooperate with other such plans, and shall not commit or permit any act which may interfere with the performance of work by any other plan.

8.8 Independent Plan: It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The plan represents that it has, or shall secure as its own expense, all personnel required to perform the services it is obligated to provide under this contract and any subsequent contract. Other persons engaged by the plan to perform work or services required by the plan under this agreement shall have no contractual relationship with the Department, and shall not be considered employees of the Department.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the plan, its officers or its agents) shall in no way be the responsibility of the Department. The plan shall hold the Department harmless from any and all such claims. Such personnel or other persons shall not be entitled to any compensation, rights or benefits from the Department including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay and retirement benefits.

8.9 Plan Responsibility: The plan shall solely be responsible for fulfilling all obligations imposed on it by this contract, with responsibility for all requirements as described. The plan shall be the sole point of contact regarding all contractual matters.

If the plan intends to utilize any subcontractor service, the subcontractor's level of effort, tasks and time allocation shall be clearly defined in the plan's contractual relationship with the subcontractor.

The plan shall agree that it shall not utilize any subcontractors in the performance of material portions of the contract without the prior written authorization of the Department.

8.10 Plan Personnel: The plan shall ensure that it is adequately staffed with competent employees to provide the full range of requirements of this contract, and all related aspects of the NHC.

The plan shall be responsible for the following in respect to its employees:

(a) Any and all employment taxes and/or other payroll withholding;

(b) Any expense associated with vehicles used by the plan's employees in the course of their employment, including monitoring compliance with all insurance required by state law;

(c) Damages incurred by the plan's employees within the scope of their duties under this contract;

(d) Maintaining worker's compensation and health insurance to the extent required by governing state law. Evidence of workers' compensation coverage shall be submitted annually to the Department; and

(e) Determination of the hours to be worked and the duties to be performed by the plan's employees.

The plan and its hirees agree that there is no right of subrogation, contribution or indemnification against the Department for any duty owed by the plan to the Department or any judgment rendered against the plan in the performance of its duties to the Department unless caused in whole or in part by a breach of the Department's duties to the plan.

The Department shall be liable for its own actions only to the extent that there is judgment under the State Tort Claims Act, Nebraska Workers' Compensation Act, or for a breach of this contract. The Department does not assume liability for the actions of the plan.

8.11 Department Personnel Recruitment Prohibition: The plan shall not knowingly recruit or employ any Department personnel who has worked on the contract, or who have had any influence on decisions affecting the contract for two (2) years following the completion of the services provided pursuant to the contract without the consent of the Department. This prohibition does not affect the right of the plan's organization to recruit employees for contracts unrelated to this contract, provided such recruitment does not create a conflict of interest.

8.12 Conflict of Interest: The plan shall provide assurances that it presently has no interest and shall not acquire any interest, either directly or indirectly, which shall conflict in any manner or degree with the performance of its services thereunder. The plan shall also provide assurances that no person having any such known interests will be employed during the performance of this contract without the consent of the Department.

8.13 Errors and Omissions: The plan shall not knowingly take unfair or illegal advantage of any errors and/or omissions in the performance of this contract by the Department. The plan must promptly notify the Department of any material errors and/or omissions by the Department that are discovered.

8.14 Beginning of Work: The plan shall not commence any billable work until the Implementation Begin Date, that is July, 1999, and subject to the effective date of enrollment of any client with the plan. The plan shall, however, agree to work with the Department to complete development and preparation activities immediately following contract negotiations, including network development.

8.15 Assignment By the Department: The rights of the Department under this contract shall not be assignable to any other entity or agency of the Department or State without prior notice to and the consent by the plan. The plan shall not unreasonably withhold its consent.

8.16 Assignment By the Plan: The plan shall not assign or transfer any interest in the contract without the prior written consent of the Department. The Department shall not unreasonably withhold its consent.

8.17 Deviations From the Contract: Any deviations from the contract shall be clearly defined by the plan, and if accepted by the Department, shall become an amendment to the contract. Any specifically defined deviations shall not be in conflict with the basic nature of the contract.

8.18 Governing Law: The contract shall be governed in all respects by the Nebraska laws. Any legal proceedings against the Department regarding this contract shall be brought before the Departmental administrative forums, or judicial forums, as permitted by law. The plan and the Department shall be in compliance with all applicable Nebraska State and Federal statutory and regulatory law. The plan shall use its best efforts to ensure that its

employees, agents and subcontractors comply with site rules and regulations while on Departmental premises.

8.19 Advertising: The plan shall not refer to the contract in commercial advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the Department without prior approval of the Department, which shall not be unreasonably withheld. News releases pertaining to the contract shall not be issued without prior approval from the Department, which approval shall be promptly given and not unreasonably withheld.

8.20 Department Property: The plan shall be responsible for the proper care and custody of any Department-owned property which is furnished for the plan's use during the performance of the contract. The plan shall reimburse the Department for any loss or damage of such property, normal wear and tear expected.

8.21 Site Rules and Regulations: The plan shall use its best efforts to ensure that its employees, agents and subcontractors comply with site rules and regulations while on Department premises.

8.22 Notices: After the award of the contract, all notices under the contract shall be deemed duly given upon delivery if delivered in person, or upon delivery by Certified Mail, Return Receipt Requested. The plan and Department shall provide the name, title and complete address of their designee to receive such notices.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

8.23 Termination Provisions: The following provisions apply in the event of termination or sanctions.

8.23.1 Loss of Appropriations: The Department may terminate this contract for loss of appropriations by Nebraska legislation or by the federal government. The Department shall give the plan written notice thirty (30) days prior to the effective date of any such termination. All obligations of the Department to make payments after the termination date shall cease and all interest of the Department shall terminate. The plan shall be entitled to receive just and equitable compensation in the amounts required by this contract for any authorized work which has been satisfactorily completed in the event of termination. In no event shall the plan be paid for a loss of anticipated profit.

8.23.2 Temporary Management: The plan shall comply with all contract provisions, and all pertinent State and Federal requirements. If the Department opts not to terminate the contract, and repeated substantial and material contract violations occur, the State of Nebraska Department of Insurance, pursuant to Neb. Rev. Stat., Section 44-4801 et seq., may allow for the appointment of temporary management to oversee the plan if a plan engages in continued egregious behavior or if there is substantial risk to the health of the clients enrolled with the plan. Clients shall be allowed to disenroll without cause if such a situation occurs. If the Department elects this remedy it shall give 90 days prior notice of same and an opportunity to the plan for a prior hearing. The plan may also elect to terminate the contract on 30 days notice should the Department recommend temporary management.

8.23.3 Client Rights: Prior to any termination, the Department shall provide a hearing and inform clients of their right to disenroll without cause, and provide an opportunity for the client to enroll with another plan.

8.23.4 Plan Responsibility: In the event of termination the plan shall promptly supply all information necessary for the reimbursement of any outstanding claims and all other relevant information owned by the Department, as described in 8.5 of this contract.

8.23.5 Intermediate Sanctions: Whenever the Department determines that the plan is substantially and materially out of compliance with the contract provisions, the Department may take any or all of the following actions:

(a) Suspend enrollment;

(b) Pursue legal processes for the recovery of damages;

(c) In the event of the plan's failure to provide a required service(s) to or on behalf of a client(s), the Department may direct the plan to provide such service, or withhold a portion or total amount of the plan's capitation payment for that client(s) plus assess a monthly administrative fee not to exceed $100 until the services are provided;

(d) Require a corrective action plan, and in the absence of the corrective plan or implementation of the corrective action plan, the Department may withhold a portion or total amount of the plan's capitation payments in the manner described in (c) or (d) above, as applicable, until such corrective action plans are completed; and

(e) Other, and similar actions, as defined in the contract.

The Department shall afford the plan notice and hearing prior to any action of termination or notice and implementation of any intermediate sanction and may allow the plan an opportunity to correct the failure before monetary or other damages or fees are assessed.

8.23.6 Default By Plan or Department: The Department may terminate the contract, if the plan substantially and materially fails to perform its obligations under this contract in a timely and proper manner. The Department shall, by providing a written notice of default to the plan, allow the plan a reasonable period of time to cure a failure or breach of contract of no less than a period of thirty (30) days (or longer at the Department's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the plan time to cure a failure or breach of contract does not waive the Department's right to impose a sanction in the manner described in Section 8.24.5 for the same or different contract breach which may occur at a different time. If the plan has failed to cure the failure or breach of contract within the specified period, the Department shall provide immediate notice of failure to cure and may give notice of intent to terminate the contract for the failure or breach if it is a material breach justifying termination. The plan may request review of the Department's intent to terminate for failure or breach through the Department's fair hearing procedure as set forth in 465 NAC and through the Nebraska Administrative Procedures Act prior to termination.

The Plan may terminate this Contract at any time if it determines the Department has substantially failed to perform a material function or duty under this Contract. In such event, the Plan must notify the Department in writing, of this intent to terminate this Contract and give the Department no less than thirty (30) days to correct the identified violation, breach or nonperformance of the Contract. If the plan determines that such violation, breach or nonperformance of the Contract is not satisfactorily addressed within this period, the Plan must notify the Department if it deems the Contract terminated. Said notices shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. Allowing the Department time to cure a failure or breach of contract does not waive the Plan's right to invoke any other remedy available at law for the same or different contract breach which may occur at a different time.

8.24 Assurances Before Termination: If any document or deliverable required pursuant to the contract does not fulfill the requirements of the contract, the plan shall deliver assurances of additional plan resources, if necessary, at no additional cost to the contract, in order to complete the deliverable, and to ensure that other schedules shall not be adversely affected.

8.25 Insolvency: The Department shall obtain from each plan proof of financial solvency, including proof of adequate protection against insolvency.

The plan shall meet the same solvency standards established by the State for commercial HMOs, or be licensed or certified by the State as a risk-bearing entity. This provision does not apply if:

(a) The plan does not provide inpatient and physician services;

(b) The plan is a public entity;

(c) The State guarantees the plan's solvency; and

(d) The plan is (or is controlled by) a federally qualified health center and meets solvency standards set by the State for such organization.

The plan shall assure that the Medicaid client shall not be liable for the plans' debts if it does become insolvent.

The Department's solvency protection requirements for the plan shall provide for protection in both the pre-insolvency and post-insolvency periods. The Department of Insurance is the designated agency for regulating plan solvency, and as such, shall coordinate all activities with the Department.

The plan shall cover the continuation of services to clients for the duration of the contract period for which payment has been made to the plan, as well as cover the continuation of services to clients confined in an inpatient facility on the date of insolvency until their discharge, or for sixty (60) days whichever is less.

8.26 Force Majeure: The plan shall not be liable for any excess cost to the Department if a failure to perform the contract arises from causes beyond the control and without the fault or negligence of the plan. Such causes may include, but are not limited to, acts of God, fire,

strikes, epidemics and quarantine restriction. The plan shall take all reasonable steps to recover from such occurrences.

8.27 Prohibition Against Advance Payment: No compensation or payments by the Department of any kind shall be made in advance of services actually performed, unless required or permitted by this contract.

8.28 Payment For Services by the Department: The following provisions shall apply:

8.28.1 Capitation Rates: In full consideration of Covered Services in the Basic Benefits Package provided by the HMO, the Department agrees to pay the Plan monthly payments based on the capitation rate specified in Addendum B attached hereto and incorporated herein by this reference. The capitation rate shall be prospectively designed to be less than the cost of providing the same services covered under this Contract to a comparable NMAP population on a Fee-for-Service basis.

8.28.2 Actuarial Basis: The capitation rate is calculated prospectively on an actuarial basis recognizing the payment limits set forth in 42 CFR 447.361, and based on geographic location, eligibility category, gender, age and type of services.

8.28.3 Renegotiation: The monthly capitation rates set forth in this article shall not be subject to renegotiation during the two years of the contract term unless such renegotiation is required by changes in Federal or State law or pursuant to NAC.

The Department shall attempt to negotiate new capitation rates for the next two year contract term at least one hundred and eighty (180) days prior to the end of the second year of the contract term. The Plan shall have the right not to renew this Contract if the new capitation rate for the next two year term is deemed to be insufficient notwithstanding any other provisions of this Contract.

8.28.4 Payment Schedule: Payment to the Plan shall be based on the Enrollment Report which the Department will distribute to the Plan electronically on or before the first day of the enrollment month. Payment for each person listed on the Enrollment Report shall be made within fifteen (15) days of the date the report is generated. The Department agrees to provide payment in compliance with the Nebraska Prompt Payment Act 81-2401 through 2408.

8.29 Invoices: Payments to the plan shall be made pursuant to this contract. Invoices for any additional or supplemental payments, agreed upon by the Department, shall be submitted by the plan to the Department.

8.30 Method of Charging: The charges described in this contract are the only charges now or hereafter to be levied by the plan.

The plan shall maintain documentation for all charges against the Department pursuant to the contract. All plan's books, records and documents relating to work performed or monies received under this contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by the Department. These records shall be maintained for a period of five (5) full years from the date of final payment, or until all issues related to an audit, litigation or other action are resolved. All records shall be maintained in accordance with generally accepted accounting principles.

The plan shall maintain an appropriate system of record-keeping for services provided to clients.

The Department shall evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract.

8.31 Audit Liabilities: In addition to, and in no way in limitation of the obligation of the contract, the plan agrees that it shall be held liable for any proper and correct Departmental audit exceptions resulting from the plan's lack of compliance with this contract. However, before the plan is obligated to return to the Department all payments made under the contract for which an exception has been taken or which has been disallowed because of such an exception it shall be entitled to an administrative hearing and judicial review as authorized by the Administrative Procedures Act. The plan shall maintain documentation for all charges and fees allowed by the contract. All plan's books, records, and documents relating to this contract will be subject to audit at any reasonable time upon reasonable notice by the Department, its designees or HCFA officials. These records shall be maintained for five (5) years. These records should be maintained in accordance with generally accepted accounting principles. The plan agrees to correct immediately any material weakness or condition reported to the Department in the course of an audit.

8.32 Taxes: The Department is not required to pay taxes of any kind and assumes no liability as a result of this solicitation. Any property tax payable on the plan's equipment which may be installed in a Departmental-owned facility shall be the responsibility of the contractor. The Department shall not pay taxes based on the contractor's income or property taxes for software.

8.33 Inspection and Approval: Final inspection and approval of all work required under this contract shall be performed by the designated Departmental officials.

The Department and/or its authorized representatives shall have the right to enter any premises where plan's or subcontractor's duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that shall not unreasonably delay business operations, or interfere with any confidential or privileged activity.

The Department, its designees, and Health Care Financing Administration (HCFA) officials, may evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

8.34 Hold Harmless: The Plan shall hold the Department harmless for all loss or damage sustained by any person as a direct result of the negligent or willful acts by the Plan, its employees or agents in the performance of this agreement including all associated costs of defending any action.

The Department shall hold the Plan harmless for all loss or damage sustained by any person as a direct result of the negligent or willful acts by the Department, its employees or agents in the performance of this agreement including all associated costs of defending any action.

8.34.1 Client Protection: Clients shall not be held liable for payments to providers or entities in the following situations:

(a) The plan or subcontractor's insolvency;

(b) The Department, as authorized by the contract, does not pay the plan; or

(c) Payments under an arrangement with the plan in excess of the amount that would be owed if the plan directly provided the service.

Federal or state laws imposing fines of no more than $25,000, or imprisonment for no more than five years, or both, may apply to providers in the case of services provided to a client enrolled with a plan and where the client is charged at a rate in excess of the rate permitted under the contract.

8.35 Confidentiality: All materials and information provided to the plan by the Department or acquired by the plan on behalf of the Department shall be regarded as confidential information in accordance with federal and state law, and ethical standards. The plan shall take all necessary steps to safeguard the confidentiality of such materials or information. The plan shall be responsible for safeguarding all information about the Medicaid client. This provision shall not, however, prevent the plan from disclosing said information in reports it or its providers may be required by law or accrediting standards to disclose in the usual course of business.

Information about clients, provider eligibility, or the amount of assistance and services provided shall be confidential. However, information shall be made available for purposes directly connected with the administration of the NHC.

The Department affords the plan the same right of confidentiality.

8.36- Severability: If any term or condition of this contract is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the plan shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

8.437 Certification of Independent Price Determination:

(a) The plan certifies that in connection with this contract:

(1) The agreed upon rates have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;

(2) Unless otherwise required by law, the agreed upon rates have not been knowingly disclosed by the plan; and

(3) No attempt has been made or shall be made by the plan to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

(b) The person signing this contract certifies that:

(1) S/he is the person in the plan's organization responsible within that organization for the decision being offered herein and that s/he has not participated, and shall not participate, in any action contrary to (a) (1-3) above; or

(2) S/he is not the person in the plan's organization responsible within that organization for the decision being offered herein, but that s/he has been authorized in writing to act as agent for the persons responsible for such decision in certifying that such persons have not participated, and shall not participate in any action contrary to (a) (1-3) above, and as their agent does hereby so certify; and s/he has not participated, and shall not participate, in any action contrary to (a) (1-3) above.

8.38 Rates: The capitated rate agreed upon in this contract shall remain fixed and valid through June 30, 2001, commencing on the Implementation Begin Date, unless otherwise agreed upon through contract amendments.

Rates agreed upon shall be fixed for each two-year period of the contract, and negotiated for each subsequent two-year contract period.

8.39 Declaration of Plan Affiliations: The plan shall comply with the following provisions and declare such affiliations to the Department of Insurance, as the Department's designee, on an annual basis:

8.39.1 Debarred Individuals: The plan shall not knowingly have an individual who has been disbarred, suspended or otherwise excluded from participating in the contract activities -

(a) As a director, officer, partner or person with beneficial ownership of more than five (5) percent of the plan's equity; and

(b) In an employment, consulting, or other similar arrangement for the provision of items and services that are significant to the plan's obligation with the Department.

The plan shall certify to the Department that the plan does not have any such affiliations, prior to the Implementation Begin Date of the contract, and at any time there is a changed circumstance from the last such certification.

The Department shall impose immediate sanctions if a plan is found to be out of compliance with these provisions if directed by the Health Care Financing Administration (HCFA). The Department cannot revoke the sanctions unless HCFA determines that compelling reasons exist for doing so.

8.39.2 Ownership: The plan shall provide full and complete information as to the identify of each person or corporation with an ownership or control interest in the plan, or any subcontractor in which the plan has a five (5) percent or more ownership interest. The plan shall submit financial statements for all owners with over five (5) percent ownership.

8.39.3 Interlocking Relationships: The plan shall report to the Department a description of certain transactions between the plan and parties in interest, and shall disclose any interlocking relationships.

8.40 Unique Identifier: Physicians who provide services shall have a unique identifier in accordance with the system established in CFR 1173(b).

8.41 Timeliness of Provider Payments: The plan shall provide payment to a provider of services on a timely basis, consistent with Medicaid claims payments procedures and the minimum standards provided below, unless the health care provider and organization agree to a capitated payment schedule.

The plan shall provide an information system that includes the capability to electronically accept claims for adjudication and make payments. Such electronic system shall have the ability to transmit data to a central data repository which complies with the requirements for confidentiality of information under the Medicare program.

The plan shall comply with the following minimum timeframes for the submission and processing claims, subject to payment for emergency services addressed in Section 13.48. Timeframes are calculated from the day the clean claim is received by the plan until the date of the postmark that either returns the claim to the provider or until posted on a electronic system.

Ninety-five percent (95%) of all "clean" claims shall be adjudicated (i.e., paid, denied, or have the deductible applied to them) within 30 days from the date of receipt, by the plan.

These performance requirements are subject to the default provisions of this contract.

8.41.1 Prompt Investigation and Settlement of Claims: The plan shall comply with the requirements related to claim forms as set forth in 471 NAC. This shall include the use of the HCFA-1500, Health Insurance Claim Form, for providers of outpatient services and Form UB-92 for hospitals providing inpatient or outpatient services. Any claim forms or submission methodology developed by the plan for use by the providers shall be approved by the Department and shall be in a format as to assure the submission of authorization and claims data are as required in this contract.

8.41.2 Definitions: For purposes of Section 8.41 of this contract, the following words shall have the following meanings, unless the context clearly indicates otherwise:

The term **" Claims"** means a request for payment for service rendered or supplies provided by a provider to a client.

The term **" Clean Claim"** means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim.

The term **" Returned Claim or Contested Claim"** means a claim that has not been adjudicated because it has a material defect or impropriety.

8.41.3 System Requirement: The plan shall establish and maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identifier of the office handling the claim on behalf of the plan.

8.41.4 Payment Standard: The plan shall pay clean claims promptly as provided above after the date the plan receives written or electronic notice of the claim. If, for

whatever reason, a claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the plan shall calculate the maximum thirty (30) day period.

8.41.5 Notice of Contested Claim: The plan shall provide written or electronic notice to the provider of a determination by the plan that the claim is a contested claim with the returned claim. The written or electronic notice shall comply with the provisions in Section 8.46.

8.41.6 Notice Requirement for Partially Contested Claim: If the plan determines that part of a claim is a contested claim and returns the claim, the plan shall provide written or electronic notice of that determination to the person submitting the claim.

8.41.7 Prohibited Action: In no instance shall the plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no impact upon the plan's ability to adjudicate the claim.

8.41.8 Notice of Claim Denial: If the plan determines that a claim provides insufficient information for the plan to pay the claim, the plan shall provide written or electronic notice of this determination to the person submitting the claim, promptly but in no instance later than thirty (30) calendar days following the date that the plan receives written or electronic notice of the claim, including the following information:

(a) Reasons for the denial of the claim;

(b) The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered;

(c) The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his/her areas code; and

(d) The date the claim was received.

Requests for information made by the plan on a contested claim shall be reasonable and relevant to the determination of whether the claim is a clean claim or claim that will be denied.

8.41.9 Effective Notices and Payments: Written notice of a claim shall be effective upon the date that the claim is received at the address provided by the plan to the providers for receipt of claims of the type submitted. However, if the provider and the plan agree to administer claims by electronic transmission, the plan shall have constructive notice of the claim as of the date the claim is posted and transmitted to the plan.

Payment from the plan shall be effective as of the date that:

(a) A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly addressed, postage-paid envelope;

(b) The date the plan posts the item to an electronic transfer system; or

(c) The date of delivery of the draft or other valid instrument equivalent to payment if (a) or (b) do not otherwise apply.

Payment and notices distributed by a plan's subcontractor shall be effective when made in compliance with this section, as appropriate.

Notices from the plan shall be effective as of the date that the notice is:

(a) Placed in the United States mail in a properly addressed, postage paid envelope;

(b) Posted to an electronic system; or

(c) Delivered if (a) or (b) do not otherwise apply.

8.41.10 Use of Intermediaries: A plan's use of subcontractors to perform one or more of the plan's claims handling functions shall not in any way mitigate a plan's responsibility to comply with all of the terms of Section 8.46 of this contract.

8.42 Financial Record Audit: The plan shall provide the Department with the right to audit and inspect books and records of the plan or its subcontractors relating to:

(a) The plan's capacity to bear the risk of potential financial losses; and

(b) Services performed or determination of amounts payable under this contract.

8.43 Risk Contract: The plan shall report annually to the Department how it is reinvesting profits into improved services for clients.

8.44 Physician Incentive Plan: The plan shall report adequate information specified in the Physician Incentive Plan (PIP) regulations to the Department in order that the Department may adequately monitor the plan. The disclosure shall contain the following information in detail sufficient to enable the Department to determine whether the incentive plan complies with the PIP requirements:

(a) Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made;

(b) The type of incentive arrangements, for example, withhold, bonus, capitation;

(c) If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus;

(d) Proof that the physician or physician group has adequate stop-loss protection;

(e) The panel size and, if patients are pooled, the approved method used;

(f) In the case of capitated physicians or physician groups, capitation payments paid to PCPs for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of providers (for example, nursing home and home health agency) services; and

(g) In the case of those prepaid plans that are required to conduct client surveys, the survey results, and which results shall be provided in a timely manner to the Medicaid clients upon request.

8.45 Contract: This contract shall be approved by the Health Care Financing Administration (HCFA) prior to its effective date. In the event that this contract is not approved, a contract with a current plan may be extended, with HCFA approval, if the new contract is not completed by the expiration date of the current contract. Upon HCFA approval of the rates set forth in Addendum B the plan shall receive Addendum B rates effective July 1, 1999.

8.46 Department's Authority: Throughout the procurement process, contracting, development and implementation phases of the NHC, the Department reserves the right to implement changes in any aspect of the NHC as it deems appropriate and necessary as long as such changes do not violate the provisions of this Agreement.

8.47 Anti-Gag Clause/Treatment Options: The plan shall ensure that the client is informed about all treatment options, regardless of cost or whether such services are covered by the plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does not require a plan to cover counseling or referral if it objects on moral or religious grounds and makes available information on its policies to clients who are enrolled with the plan, or who may enroll with the plan, within ninety (90) days of a policy change regarding such counseling or referral services.

8.48 Y2K Preparedness: The plan and the Department represent that they have each taken all necessary and reasonable actions to be Y2K compliant for all matters relevant to their respective performance under this contract. The plan will provide the Department a copy of Medicare Y2K Certification as verification of preparedness.

ARTICLE IX

9.0 PLAN RESPONSIBILITIES - CLIENT PARTICIPATION AND ENROLLMENT PROCESSES

9.1 Introduction: The Department maintains responsibility for the enrollment of clients into managed care, through various departmental and contractual arrangements. The use of an " enrollment broker" precludes any direct enrollment activities by the plan, unless specifically addressed in the contract. The major focus of this section is enrollment of the " mandatory" managed care clients into the Basic Benefits Package in the Designated Coverage Areas pursuant to this contract.

The plan shall have an understanding of the client population and enrollment processes for the NHC, and assist the Department and the enrollment broker in providing adequate information to the client about the plan's participation. The plan shall work cooperatively with the Department to resolve issues relating to client participation and enrollment processes, and shall have the technological capability and resources available to interface with the Department's support systems.

9.2 Mandatory and Excluded Clients

9.2.1 Mandatory for the NHC Basic Benefits Package: The following Medicaid-eligible clients are required to participate in the NHC, if the client's eligibility assistance case is managed by the Health and Human Services (HHS) District Office in the designated coverage areas, unless excluded pursuant to Section 9.2.5 of this contract:

(a) Clients participating in the Aid to Dependent Children Program - Grant/Medical (Title 468 NAC). For purposes of the NHC, this includes clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection pursuant to Title 477 NAC;

(b) Clients participating in the Aid to Aged, Blind, and Disabled Program Grant/Medical pursuant to Title 469 NAC; and

(c) Clients participating in the Child Welfare Payments and Medical Services Program, i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases pursuant to 479 NAC.

9.2.2 Automated Interface: The client's managed care status (mandatory and excluded) shall be determined by an automated interface between the Department's eligibility system and the Managed Care File, and shall be based on information entered on the eligibility system by the Health and Human Services (HHS) local office staff, and known at the time of the managed care determination.

9.2.3 Designated Coverage Area(s) for the NHC Basic Benefits Package: For purposes of the Basic Benefits Package, the designated coverage areas shall include those mandatory clients whose eligibility assistance case is managed by the

Health and Human Services (HHS) Office, primarily in Douglas and Sarpy Counties in the Eastern HHS District Office (commonly referred to as District 8), and in the Southeastern District Office, primarily in Lancaster County (commonly referred to as District 7).

9.2.4 NHC Components: The NHC shall provide a Primary Care Case Management (PCCM) Network and one or more Health Maintenance Organizations (HMOs) in the designated coverage areas for the provision of the Basic Benefits Package.

Enrollment Broker Services (EBS) for the designated coverage areas shall be provided through a separate contract with the Department.

The Mental Health and Substance Abuse (MH/SA) Services component of the NHC shall be provided on a statewide basis as a " carve-out" from the Basic Benefits Package. The provision of MH/SA services is not part of this contract, except as specifically described.

9.2.5 Excluded Clients: The following clients shall be excluded from the NHC (based on the information known to the HHS eligibility system):

(a) Clients with Medicare coverage pursuant to 471 NAC 3-000;

(b) Clients residing in nursing facilities and receiving custodial care. pursuant to Section 9.20 of this contract;

(c) Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) pursuant to 471 NAC 31-000;

(d) Clients who are residing out-of-state (i.e., children who are placed with relatives out-of-state, and who are designated as such by HHS personnel;

(e) Certain children with disabilities who are receiving in-home services (also known as the Katie Beckett program) pursuant to 469 NAC;

(f) Aliens who are eligible for Medicaid for an emergency condition only pursuant to Title 469 NAC;

(g) Clients participating in the Refugee Resettlement Program - Grant/Medical pursuant to Title 470 NAC;

(h) Clients receiving services through the following home and community-based waivers pursuant to Title 480 NAC for -

(1) Adults with mental retardation or related conditions;

(2) Aged persons or adults or children with disabilities;

(3) Children with mental retardation and their families;

(4) Infants and toddlers with disabilities (also known as the Early Intervention Waiver); and

(5) Any other group for whom the Department has received approval of a 1915(c) waiver of the Social Security Act;

(l) Clients who have excess income (i.e., spenddown - met or unmet) pursuant to 471 NAC 3-000;

(j) Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state, pursuant to 469 NAC;

(k) Clients participating in the State Disability Program pursuant to Title 469 NAC;

(l) Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28-000;

(m) Transplantation recipients pursuant to 471 NAC 10-000 and Section 9.18 of this contract;

(n) Clients who have received a disenrollment/waiver of enrollment pursuant to Section 9.18 and 9.19 of this contract; and

(o) Clients with private health insurance for medical/surgical benefits determined to be qualified coverage or whose insurance coverage is pending verification. Qualified coverage includes verified standard comprehensive coverage, verified HMO or prepaid plan with specified providers, or verified CHAMPUS. Note: Clients with private health insurance shall be " excluded" from NHC until the coverage is verified; at that time, clients not having qualified coverage will be required to participate in NHC pursuant to 471 NAC 3-000.

9.2.6 Fee-for-Service Coverage for Excluded Clients: Medicaid coverage for clients excluded from NHC participation shall remain on a fee-for-service basis. Clients who are excluded from NHC cannot voluntarily enroll in the NHC.

9.2.7 Periodic Status Change: Due to changes in a client's Medicaid eligibility and " mandatory" managed care status, a client's status may periodically change. The plan shall be responsible for the provision of the Basic Benefits Package for the client as long as s/he is identified as a member of his/her plan, subject to rules discussed elsewhere in this contract such as Section 9.11 relating to resolution of discrepancies and rules pertaining to disenrollment.

9.3 Enrollment for the NHC Basic Benefits Package

9.3.1 Process at Initial Eligibility Interview: HHS local office staff shall provide the client with written information about the NHC when the individual applies for assistance.

At the time of the initial eligibility interview, HHS local office staff shall inform the client of the requirement to participate in the NHC.

9.3.2 Enrollment for the Basic Benefits Package: The client shall complete the following activities:

(a) Receive information on the NHC from the EBS;

(b) Complete the health assessment. Information from the health assessment shared with the plan, according to HHS regulations; and

(c) Choose a Primary Care Physician (PCP)/plan. Note: Except as described in 9.6 of this contract, family members may select different PCP/plans, but shall be encouraged to choose the same plan.

9.3.3 Forty-Five Day Enrollment Process: The PCP/plan and all enrollment activities shall be completed and entered on the Managed Care File by the EBS within forty-five (45) calendar days following a determination of eligibility, i.e., the client's case is entered on the Department's eligibility system as an " active" case. After forty-five calendar days, if a choice has not been made, automatic assignment pursuant to 9.14 of this contract shall be completed by the Department and shall occur the first month possible, given the system cutoff. Enrollment activities may be completed via face-to-face contact, telephone calls, or the mail.

9.3.4 Order of Enrollment: The plan shall accept Medicaid clients in the order in which they are enrolled through the EBS.

9.3.5 Client Choice: The client shall have the opportunity to choose the PCP/plan of his/her choice, to the extent possible and appropriate.

9.3.6 Prospective Enrollment: Enrollment in the NHC is prospective, and is activated the first month possible, given system cutoff.

9.3.7 Authorization for Release of Information: Authorization for Release of Information is provided under Nebraska Statute 68-1025.

9.4 Reenrollment for the Basic Benefits Package

9.4.1 Reenrollment Rules Within Two Months of Disenrollment: If the client is re-enrolling in the NHC within two (2) months of the disenrollment, the client shall automatically be enrolled with the previous PCP/plan, effective with the first month possible given system cutoff. The client may be asked by the EBS to review the previously completed health assessment following the reenrollment. The client is free to choose a different PCP/plan; however, the reenrollment process shall be " automatic" and shall be activated prospectively unless the client contacts the EBS. The client's choice shall take precedence over the systematic process, if the choice is made prior to system cutoff.

9.4.2 Reenrollment Rules Beyond Two Months of Disenrollment: Reenrollment beyond two months will be based on client choice. The EBS shall contact the client and discuss enrollment back into the NHC.

9.5 Enrollment for the Blind/Disabled and Departmental Ward/Foster Care Clients:

The following procedures apply for clients who are eligible for assistance in the Blind/Disabled categories, or who are Departmental Wards or in Foster Care:

9.5.1 Blind/Disabled Clients: The EBS shall outreach to the blind/disabled clients who are mandatory for NHC with letters and telephone contacts (as appropriate, depending upon the needs of the client), according to standard enrollment activities. A client, who is blind/disabled, will be excluded from auto-assignment. After completing the full enrollment process, the EBS shall make one last outreach attempt by sending the client a " pre-nomination" letter identifying a potential PCP/plan based on information known about the client on the eligibility and claims history file. The client shall have an additional fifteen (15) calendar days from the date of the pre-nomination letter to make a change in the proposed PCP/plan. If the client does not make a change, the EBS shall activate the enrollment.

In some cases, the EBS may delay the activation of the client's enrollment for an additional thirty (30) day period to allow the EBS to coordinate necessary services with the prospective PCP/plan.

If the EBS determines that the client does not have any medical issues that need immediate attention by the PCP/plan, the enrollment may be " activated" immediately following completion of the enrollment activities described above.

The EBS shall complete the enrollment activities by entering the information on the Managed Care File, and contacting the PCP/plan, to alert them to any immediate medical or social issues.

The EBS shall be responsible for tracking the extended activation period, and reporting such activity to the Department.

9.5.2 Departmental Wards/Foster Care Clients: The EBS shall coordinate enrollment activities with the Department's Protection and Safety (PS) worker responsible for the case management of the ward/foster child. The PS worker shall work with the client and the client's family or legal representative, as appropriate, to complete the health assessment and explore the most appropriate choice of PCP/plan.

The PS Worker shall notify the EBS of the client's choice at the time the health assessment is completed.

The EBS shall work with the PS Worker to outreach to the Department Ward/Foster Care client who are mandatory for NHC with letters and telephone contacts (as appropriate, depending upon the needs of the client), according to standard enrollment activities. A Department Ward/Foster care client will be excluded from auto-assignment. After completing the full enrollment process, the EBS shall make one last outreach attempt by sending the client a " pre-nomination" letter identifying a potential PCP/plan based on information known about the client on the eligibility and claims history file. The client shall have an additional fifteen (15) calendar days from the date of the pre-nomination letter to make a change in the proposed PCP/plan. If the client does not make a change, the EBS shall activate the enrollment.

In some cases, the EBS may delay the activation of the client's enrollment for an additional thirty (30) day period to allow the EBS to coordinate necessary services with the prospective PCP/plan.

If the EBS determines that the client does not have any medical issues that need immediate attention by the PCP/plan, the enrollment may be " activated" immediately following completion of the enrollment activities described above.

The EBS shall be responsible for tracking the extended activation period, and reporting such activity to the Department.

The EBS shall complete the enrollment activities by entering the information on the Managed Care File, and contacting the PCP/plan, to alert them to any immediate medical or social issues.

9.5.3 Changes in Eligibility: The EBS shall be notified, by the Department's interface with the eligibility system, if the client's NHC status changes (e.g., mandatory to non-mandatory). Each change in status may require the EBS to contact the client and complete an enrollment for the Basic Benefits Package, unless reenrollment rules apply pursuant to Section 9.4 of this contract.

9.6 Enrollment of a Pregnant Woman

9.6.1 Enrollment of the Unborn When the Mother is Ineligible: The EBS shall focus the enrollment activities on the unborn. Depending on the mother's preference, a pediatrician, family practitioner or general practitioner will be selected as the PCP for the unborn. The unborn's plan shall be responsible for any necessary referrals for pregnancy-related services for the mother. This provision shall apply through the postpartum period, defined as the end of the month in which the 60th day following the end of the pregnancy occurs. The EBS shall notify the plan and coordinate the PCP selection and immediate referrals for the mother.

9.6.2 Enrollment of a Pregnant Woman and Her Unborn Child for the Basic Benefits Package: During the enrollment process, an eligible pregnant woman shall be required to choose the same plan, but not necessarily the same PCP, for herself and her eligible unborn/newborn child. Enrollment changes (i.e., to a different plan or PCP) may be made as often as allowed for any other client participating in the NHC, as long as mother and unborn/newborn are both enrolled with the same plan. The following shall apply:

(a) The requirement for mother and unborn/newborn to be in the same plan extends through the postpartum period, defined as the end of the month in which the 60th day following the end of pregnancy occurs;

(b) The mother and unborn/newborn may be enrolled in separate plans when requested by the client based on good cause. Good cause includes, but is not limited to, situations in which one plan is unable to meet the needs of both clients despite reasonable efforts to accommodate their needs; and

(c) The request for enrollment in separate plans shall be submitted to the EBS, who gathers any necessary information. The request is then submitted to the Department within two (2) working days. The Department shall approve or deny the request within five (5) working days. The client and PCP/plans are notified of the approval or denial of the request by the Department.

9.7 Follow-up Contact by the Designated Enrollment Broker

9.7.1 Follow-up Contact: Follow-up contact shall be conducted by the EBS until enrollment occurs or the client is automatically assigned to a PCP/plan. The EBS shall make reasonable efforts to contact those clients who have been automatically assigned but who have not had the benefit of an explanation of the NHC.

Follow-up contact may include, but is not limited to, the following:

(a) Face-to-face visits;

(b) Telephone calls;

(c) Home visits;

(d) Informational mailings; and

(e) After hours/evening meetings.

9.7.2 Priorities for Follow-up Contact: The EBS shall give priority in follow-up contact to the following persons:

(a) Pregnant women;

(b) Clients with urgent/special needs; and

(c) Children age 20 and the younger.

9.8 Enrollment Rules

9.8.1 Completion of the Enrollment Process: The client or the client's legal representative shall complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:

(a) A friend or relative of the client, who does not have legal authority, may complete the informational portion of the enrollment process and health assessment, if the individual is determined to have sufficient knowledge of the client's health status;

(b) The client or his/her legal representative (i.e., guardian, conservator, or power of attorney (POA) if the POA has this level of authority) shall make the choice of a PCP/plan; and

(c) Child Welfare staff may act on a Department ward's behalf. The child's foster parents must be involved in the selection of the PCP/plan. Child Welfare staff shall consider whether it is appropriate for the biological parents to be involved in the enrollment activity/choice of PCP/plan.

9.8.2 Limitation on Plan Contact: The plan shall not have any direct contact with the client or the client's legal representative, family or friends prior to the client becoming enrolled with his/her plan without prior approval by the Department, unless

the contact is initiated by the EBS in an effort to facilitate the choice of PCP/plan and as it relates to continuity of care issues.

9.9 Effective Date of NHC Coverage

9.9.1 Effective Date of Coverage: The effective date of NHC coverage shall be the first day of the month following the month during which eligibility is determined and enrollment is completed and activated, given system cutoff.

9.9.2 Exception to Date of Coverage: The effective date of coverage for a client who is hospitalized shall be pursuant to Section 9.13 of this contract.

9.9.3 Services Before Enrollment in NHC: If eligibility is determined, Medicaid services received before the month of NHC coverage shall be paid on a fee-for-service basis pursuant to Title 471 NAC.

9.10 Client Notification of NHC Coverage

9.10.1 Client Notification: The client or the client's legal representative shall be notified of NHC coverage and shall be issued a notice of finding and NHC Identification (ID) Document.

9.10.2 Client Notice of Right to Change: Through the EBS functions, and written materials and notice, the client shall be kept informed of his/her right to change PCP and/or plan.

9.11 Plan Notification of NHC Clients

9.11.1 Plan Notification: The plan shall be notified of clients enrolled with their plan via a monthly enrollment report (in the form of a data file). The Department shall electronically transmit the enrollment report to the plan on or before the first day of each enrollment month. The enrollment report provides the plan with ongoing information about its clients and shall be used as the basis for the monthly capitation payments. The enrollment report shall be generated in the following sequence: clients enrolled and clients disenrolled with the plan.

9.11.2 Notification of a Discrepancy: The plan shall be responsible for providing the NHC Basic Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report shall be reported to the Department for resolution. The plan shall continue to provide and authorize services until the discrepancy is resolved. The Department shall be responsible for all covered services, in the event that a client is eligible for NHC Basic Benefits Package but is not reflected on the enrollment report.

If the Plan notices a discrepancy between a client's current enrollment as eligible for Plan services and facts indicating the member is not eligible for NHC or Medicaid the Plan may report this discrepancy to the Department which will promptly resolve the discrepancy and disenroll the clients if ineligible for NHC.

9.11.3 Resolution of a Discrepancy: The Department's Eligibility and Enrollment databases used to build the Enrollment File shall be the official source of validation in the case of a discrepancy. Once the cause for the discrepancy is identified, the

Department shall work cooperatively with the plan to identify responsibility for the client's services until the cause for the discrepancy is corrected. In reconciling the discrepancy, an adjustment shall be made in the following manner. The following rules for reconciliation and reimbursement shall apply unless specifically addressed elsewhere in this contract:

(a) If the Department assumes claims payment for the client, the plan shall reimburse the Department for any capitation payment made for that month of service;

(b) If the plan assumes claims payment for the client, the plan shall receive a capitation payment; and

(c) If the error results in an incorrect amount of capitation payment, the difference shall be appropriately reimbursed, either to the plan or to the Department.

9.12 Client Transition Into NHC

9.12.1 Transition Period During First Month: Within the first month of enrollment, the plan shall be responsible for providing each client general information about the plan, e.g., member handbook, etc.

9.12.2 Transition " As Needed" : On an " as needed basis" , the plan shall work cooperatively with a client who is experiencing difficulty in transitioning to a managed care environment during the first sixty (60) days of enrollment.

9.12.3 Transition for a Special Needs Client: For a client who is specifically identified by the EBS to have a special need, e.g., a client in the Disabled/Blind category, the plan shall be responsible for coordinating service needs with the EBS, the PCP and the client during the first sixty days (60) of enrollment to ensure a smooth transition into the NHC.

9.12.4 Requirements of the Transition Period: The transitional period may require, but is not limited to, the plan providing additional case management and member services, contracting with out-of-network providers to ensure continuity of care, and taking into consideration the unique needs of the client in understanding and following the managed care rules, e.g., referral and prior authorizations for services.

9.13 Enrollment While Hospitalized

9.13.1 Enrollment Rules: When a Medicaid client is an inpatient in an acute care medical/surgical or rehabilitation facility on the day that the client's participation in NHC is effective, the Department shall remain responsible for the hospitalization until the client is discharged from the facility or transferred to a lower level of care. Authorization for inpatient hospitalizations for rehabilitation services must be obtained from the Department's contracted PRO. The plan is responsible for related services in the Basic Benefits Package during this period of time.

9.13.2 Disenrollment Rules: The plan shall be responsible for a NHC client, who is an inpatient for acute medical/surgical or rehabilitation services on the first of the month that the Medicaid eligible client is no longer enrolled in a plan (i.e.,

disenrolled), until the client is discharged from as set forth in 482.NAC 2-002.O5D and defined in 471 NAC. The Department is responsible for related services in the Basic Benefits Package after disenrollment occurs if the client remains eligible for Medicaid..

9.14 Auto-Assignment for the Basic Benefits Package

9.14.1 Auto-Assignment Rules: All enrollment activities shall be concluded within forty-five (45) calendar days. If a choice of PCP/plan is not made, automatic assignment shall occur. The client will be automatically assigned to a PCP/plan, based on criteria established by the Department pursuant to this contract.

9.14.2 EBS Report of Auto-Assignments: The Department shall provide a report to the EBS prior to the effective date of the auto-assignment enrollment. The EBS shall complete any necessary transfers if an incorrect or inappropriate assignment is identified.

9.14.3 Plan Notification of Auto-Assignment: The auto-assignment of a client shall be indicated on the plan's Enrollment Report.

9.14.4 Auto-Assignment Priorities: The following priorities shall apply:

(a) The Department's auto-assignment algorithm shall give priority to provider-client proximity and shall maintain family members with the same PCP/plan, if appropriate; and

(b) For a client in the Blind/Disabled and Department Ward/Foster Care categories, the EBS shall facilitate an assignment by " pre-nominating" a PCP/plan by taking into consideration eligibility and claims history information known about the client.

9.14.5 Distribution of Clients During Auto-Assignment: The Department shall attempt, but shall not guarantee, an equal distribution of clients to available plans during auto-assignment.

9.15 Client Requested Transfers

9.15.1 Definition of a Transfer: A transfer is a change in a client's enrollment from one PCP to another PCP or from one plan to another. A transfer may be made at the client's request pursuant to Section 9.15 of this contract or at the PCP/plan's request pursuant to 9.16 of this contract.

9.15.2 Client Transfer Requests: The client shall contact the EBS to request a transfer. A client may request a transfer at any time. The transfer shall be effective the month following the request but no later than the second month following the request. The EBS shall assist the client in selecting a new PCP or plan by:

(a) Discussing the reasons for transfer with the client and attempting to resolve any conflicts, when in the client's best interest; and

(b) Reviewing the client's needs to facilitate the client's choice of PCP or plan.

9.15.3 Transfer Entry and Notification: The EBS shall process the transfer and enter the information on the Managed Care File. A notice shall be issued by the Department to the client or his/her legal representative when the transfer is completed; the PCP/plan shall be notified via the monthly Enrollment Report.

9.15.4 Limitation on Plan Involvement: The plan may work with the EBS to resolve any issues raised by the client at the time of request for transfer; but shall not coerce or entice the client to remain with them as a member or transfer.

9.15.5 Exception to the Transfer Rules: The following rules apply for a mother and her unborn/newborn:

(a) When requested by the client, the mother and unborn/newborn may be enrolled in separate plans based on good cause. Good cause includes, but is not limited to, situations in which one plan is unable to meet the needs of both clients despite reasonable efforts to accommodate their needs; and

(b) The request for enrollment in separate plans must be submitted to the EBS, who shall gather any additional information needed. The request shall be submitted to the Department within two (2) working days. The Department shall approve or deny the request within five (5) working days. The Department shall notify the client and PCP/plans of the approval or denial of the request.

9.16 PCP/Plan Requested Transfers

9.16.1 Definition of a Transfer: A transfer is a change in a client's enrollment from one PCP to another PCP or from one plan to another. A transfer may be made at the client's request pursuant to Section 9.15 or at the PCP/plan's request pursuant to Section 9.16.

9.16.2 PCP/Plan Transfer Requests: The PCP/plan may request that the client be transferred to another PCP or plan, based on the following or similar situations:

(a) The PCP/plan has sufficient documentation to establish that the client's condition or illness would be better treated by another PCP/plan;

(b) The PCP/plan has sufficient documentation to establish that the client/provider relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;

(c) The individual physician retired, left the practice, died, etc.;

(d) Travel distance substantially limits the client's ability to follow through the PCP services/referrals; or

(e) The PCP/plan has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the NHC service by the client.

9.16.3 Plan Documentation: The plan shall provide documentation that attempts were made to resolve the reason for the transfer request through contact with the client or his/her legal representative, the PCP, or other appropriate sources.

The plan shall document that accommodating the needs of the client would create an undue burden on the PCP/plan. Such documentation shall include, but is not limited to, the following:

(a) The plan does not have any PCPs in its network with special qualifications, as demonstrated by objective credentialling standards and standards for the care and management, to treat a particular condition;

(b) The plan has made reasonable efforts to locate another PCP within its network;

(c) The PCP has demonstrated that s/he does not have the requisite skills and training to furnish the care and that s/he has made reasonable efforts to attempt to enlist additional consultation; and

(d) The PCP is unable, based on objective evidence, to establish a relationship with a client.

9.16.4 Continued Responsibility for PCP/Plan: The PCP/plan shall maintain responsibility for providing the NHC benefits to the client until a transfer is completed.

9.16.5 Reasonable Accommodations: The plan shall assist the PCP and specialist in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for clients with special needs, e.g., HIV/AIDS.

9.16.6 Limitation on PCP/Plan Request: The PCP/plan may not request a transfer due to an adverse change in the client's health, or adverse health status.

9.16.7 Procedure for PCP/Plan Transfer Requests: The following procedure shall apply when a PCP/plan requests a transfer:

(a) The PCP/plan shall contact the EBS and provide documentation of the reason(s) for the transfer. The plan shall be responsible for investigating and documenting the reason for the request. Where possible, the plan shall provide the PCP assistance, education, etc., to try to maintain the "medical home";

(b) The EBS shall review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;

(c) The EBS shall submit the request to the Department within ten (10) days of the request;

(d) The Department approves or denies the request for transfer within five (5) working days and responds to the EBS; and

(e) The EBS shall enter the Department's decision in the Managed Care File. The client and PCP/Plan shall be notified of the approval or denial of the transfer.

9.16.8 Action Following Approval: If a transfer is approved, the EBS shall contact the client and assist the client in selecting a new PCP or plan. If the client does not select a PCP or plan by forty-five (45) calendar days after the decision, automatic assignment shall occur. The effective date of the transfer is the first of the month possible, given system cutoff.

9.17 Transfer While Hospitalized: The following rules apply:

9.17.1 Plan Responsible for Admission: When an NHC client is hospitalized as an inpatient for medical/surgical or rehabilitation services on the first day of the month that a transfer to another plan is effective, the plan which admitted the client to the hospital shall be responsible for the hospitalization and NHC Basic Benefits Package until an appropriate discharge from the hospital or for sixty (60) days, whichever is earlier.

9.17.2 Plan Client Is Transferring To: The plan that the client is transferring to shall be responsible for the hospitalization and the related services in the Basic Benefits Package, beginning the day of discharge or on the 61st day of hospitalization following the transfer, whichever is earlier.

9.17.3 Coordination Requirements: The plans shall work cooperatively with the EBS and the Department to coordinate the client's transfer.

9.18 Automatic Disenrollment/Waiver of Enrollment

9.18.1 Disenrollment/Waiver of Enrollment Due to Eligibility Changes: Disenrollment shall occur automatically in the following situations:

(a) The client's Medicaid case is closed or suspended;

(b) A sanction is imposed on the client; or

(c) The client is no longer mandatory for NHC.

9.18.2 Waiver of Enrollment/Disenrollment Rules: The disenrollment shall be prospective and effective first month possible following the decision, given system cutoff. A waiver of enrollment occurs prior to any enrollment activities being completed.

The disenrollment or waiver of enrollment, if approved, shall apply until the reason for the disenrollment or waiver of enrollment no longer applies.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

9.18.3 Notice of Disenrollment: The Department shall notify the client and PCP/plan of the disenrollment. Disenrollment shall be prospective and effective the first month possible, given system cutoff.

9.18.4 Hospitalization-Related Disenrollments: Disenrollment from NHC shall occur automatically in the following situations due to a change in mandatory status for NHC. If the client is receiving inpatient hospital services at the time of disenrollment, the following rules apply:

(a) Disenrollment due to loss of Medicaid eligibility: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services on the first day of a month that the client is no longer eligible for Medicaid benefits, the plan shall not have any responsibility for services provided to the client effective the first day of the month the client is no longer Medicaid eligible.

(b) Disenrollment due to Medicare eligibility: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services on the first day of the month that the client's Medicare coverage has been entered on the Department's eligibility system and is effective, the plan shall no longer be responsible for the hospitalization effective with the client's disenrollment from NHC.

The plan shall coordinate benefits with Medicare until the client's disenrollment from NHC is effective.

(c) Disenrollment due to Transplant: All services provided to the NHC client from the day of the prior-authorized transplant or the day that preparatory treatment (chemotherapy or radiation therapy) for bone marrow transplants begins shall be reimbursed to the provider of service on a fee-for-service basis by the Department. The plan shall notify the Department of the date of the transplant. The Department shall initiate disenrollment of the client from NHC. The Department's eligibility system shall reflect the client's disenrollment from NHC the first month possible, given system cutoff. Transplant recipients are permanently excluded from NHC participation. If it is known, at the time of enrollment, that the client is a transplant recipient, the client shall be granted a waiver of enrollment.

(d) Disenrollment due to eligibility category change: When an NHC client is receiving inpatient for acute medical/surgical or rehabilitation hospital services is disenrolled from NHC due to an eligibility status change (e.g., the client is no longer in a mandatory group for NHC participation), the plan shall be responsible for the hospitalization and related services in the Basic Benefits Package until an appropriate discharge from the hospital occurs or for sixty (60) days, whichever is earlier.

If at the time of disenrollment the client is to be transferred to another level of care (e.g., acute rehabilitation, home health, etc.) when discharged from the hospital, the plan shall inform the provider that the client is no longer participating in NHC and shall instruct the provider to contact the Department's Contracted PRO for certification and authorization of services, as appropriate.

(e) Disenrollment due to Medical Status Change: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services and is disenrolled from NHC due to a medical status change (e.g., the level of care the client requires changes from acute care services to custodial care), the plan is responsible for the hospitalization and all related services in the Basic Benefits Package until an appropriate discharge from the hospital occurs or for sixty (60) days, whichever is earlier.

If the client is to be transferred to another level of care (e.g., acute rehabilitation, home health, etc.) when discharged from the hospital, the plan shall inform the provider of service that the client is no longer participating in NHC and shall instruct the provider to contact Department's contracted Peer Review Organization (PRO) for certification and authorization of services, as appropriate.

9.19 Manual Disenrollment/Waiver of Enrollment

9.19.1 Special Circumstance: The Department shall " manually" disenroll/waive the client in the following situations by entering the disenrollment/waiver of enrollment on the Managed Care File:

(a) The client is a transplantation recipient; or

(b) The client is residing out of the medical/surgical areas and the Department determines that it is no longer appropriate for the client to remain in the Basic Benefits Package of the NHC.

9.19.2 Waiver of Enrollment/Disenrollment Rules: The disenrollment shall be prospective and effective the first month possible following the decision, given system cutoff. A waiver of enrollment occurs prior to any enrollment activities being completed.

The disenrollment or waiver of enrollment, if approved, shall apply until the reason for the disenrollment or waiver of enrollment no longer applies.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

9.19.3 Notice of Disenrollment: The Department shall notify the client and PCP/plan of the disenrollment. Disenrollment shall be prospective and effective the first month possible, given system cutoff.

The client is notified of the disenrollment/waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis.

The Department shall report all disenrollments to the plan on the enrollment report.

9.19.4 Disenrollment/Waiver of Enrollment for Pregnant Woman: The Department shall " manually" disenrollment/waive enrollment of a client by entering the disenrollment/waiver of enrollment on the Managed Care File for a client

whose mandatory status for NHC begins in her third trimester of pregnancy and she is seeking care from a provider (i.e., primary care physician or hospital) who is not affiliated with a plan, or is affiliated with a plan but is closed to new enrollment. The following rules apply:

(a) Disenrollment (i.e., due to an enrollment where pregnancy is not known, such as auto-assignment) or waiver of enrollment requests for a pregnant woman can only be made by the client and/or the EBS;

(b) The disenrollment/waiver of enrollment shall apply until the reason for the waiver of enrollment no longer applies. In the case of a pregnant woman, this provision would apply through the postpartum period, defined as the end of the month in which the 60th day following the end of the pregnancy occurs;

(c) If the request is submitted to the EBS, the EBS shall submit the request, including required forms and documentation, to the Department within two (2) working days of the request. The Department shall enter the waiver of enrollment the first month possible, given system cutoff;

(d) The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC;

(e) The client is notified of the waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis; and

(f) The Department shall report all disenrollments to the plan on the enrollment report.

9.20 Admission to Nursing Facility Care

9.20.1 Nursing Facility Admission-Skilled/Rehabilitative Level of Care: Admission to a nursing facility for skilled/rehabilitative care may affect the client's enrollment in NHC. The following rules apply:

(a) When a NHC client is admitted to a nursing facility, the plan shall determine the level of care the client requires skilled/rehabilitative or custodial/maintenance - using Medicare's definition for skilled care; and

(b) When the level of care the client requires is skilled/rehabilitative, the client shall not be disenrolled from NHC. The plan shall be responsible for the client while in skilled level of care.

9.20.2 Nursing Facility Admission-Custodial Level of Care: Admission to a nursing facility for custodial care may affect the client's enrollment in NHC. The following rules apply:

(a) When the client is admitted to a nursing facility for custodial care, the Department shall assume financial responsibility for the facility charges. The plan shall continue responsibility for all related services included in the Basic Benefits Package until disenrollment of the client from NHC; and

(b) Disenrollment from NHC shall occur the first month possible, given system cutoff, or first of the month the Department and the plan agree that the client's level of care is custodial, whichever is earlier.

9.20.3 Plan Responsibility for PCP Coverage: When the client is admitted to a nursing facility and the client's PCP does not see patients at the facility, the plan shall work cooperatively with the client and the nursing facility to locate a PCP for the client. The plan shall make arrangements to ensure reimbursement of PCP services provided by the client's nursing facility physician, for referrals, and for all services included in the Basic Benefits Package until the client is disenrolled from NHC, or effective with the first of the month the Department and plan agree that the client's level of care is custodial, which is earlier.

9.20.4 Transportation Needs While in the Nursing Facility: Transportation services are included in the nursing facility's per diem for most medical services.

9.20.5 Definitions: The following definitions apply:

(a) Clients residing in a nursing facility in an assisted living situation, at a domiciliary or room and board rate, are not residents of the nursing facility. These clients receive room and board only. Clients receiving room and board services in a nursing facility shall not be disenrolled from NHC unless the plan determines that a change to custodial level of care is appropriate:

(b) For purposes of NHC, skilled nursing services are those nursing facility services provided to eligible clients which are skilled/rehabilitative in nature as defined by Medicare and the nursing facility admission is expected to be short term; and

(c) Custodial services are those nursing facility services as defined in 471 NAC and the nursing facility admission is expected to be of long term or permanent duration.

ARTICLE X

10.0 GOALS/MEASURES - CLIENT PARTICIPATION AND ENROLLMENT PROCESSES

10.1 Goal: Ensure that the PCP/plan is culturally diverse and sensitive to the cultural needs of the NHC clients in all aspects of the NHC.

10.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall address the plan's proposed activities such as cultural sensitivity training for staff and providers, participation in/sponsorship of community events, increased numbers of culturally diverse staff and providers, etc. The workplan shall include specific activities, dates/times, targeted audiences, and designated staff responsible for the activity.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

10.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedures. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to promote cultural diversity and sensitivity on a quarterly basis.

10.2 Goal: Enhanced support for the client during the initial month(s) of enrollment to promote a smooth transition into managed care pursuant to Section 9.12.

10.2.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include specific activities such as additional education opportunities or printed materials that address the appropriate use of managed care. The workplan shall describe how the plan will incorporate the special needs of the Medicaid population into the plan's operational and management activities such as "flexible" referral/prior authorization requirements, enhanced case management activities, and coordination activities with the EBS. The workplan shall include specific activities, dates/times, targeted audiences, and designated staff responsible for the activity.

The workplan shall also address the enhanced procedures required for the enrollment of clients in the blind/disabled categories, and the departmental ward/foster care categories pursuant to Section 9.5 of this contract.

The initial workplan shall address the plan's proposed activities for the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that includes the requirement for review by the Department, and an anticipated distribution plan.

10.2.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.2.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedures. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.3 Goal: Operational components that adequately address the challenges of providing managed health care to the client who, on the average, will not be in the NHC for an extended, or consistent period of time.

10.3.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall address the challenges of working with the Medicaid population, given the movement of the average client in and out of Medicaid and the NHC. Include how these approaches will be incorporated into the plan's operational and management activities such as training for staff and providers, enhanced care management functions, innovative ways to promote continuity of care, and

maintenance/coordination of medical records/medical history, etc. The workplan shall include specific activities, dates/times, targeted audiences, and designated staff responsible for the activity.

The workplan shall also address the enhanced procedures required for clients who are re-enrolled with the same PCP/plan within two months of disenrollment pursuant to Section 9.4 of this contract.

The initial workplan shall address the plan's proposed activities for the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that includes the requirement for review by the Department, and an anticipated distribution plan.

10.3.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.3.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedures. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.4 Goal: Operationalizing NHC procedures that promote the efficient and effective sharing of information between the plans, the EBS and the Department.

10.4.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify how the plan will incorporate use of the NHC forms and related procedures into its daily operations. The sharing of information, e.g., insurance, Medicare, birth information, waiver of enrollment/disenrollment-related issues, etc., is critical to the accurate reporting and determination of managed care participation. The plan shall identify its training protocols for staff on how the forms will be used, key contact personnel responsible for the efficient flow of information, and how the plan will evaluate the effectiveness of the NHC processes.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.4.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.4.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedures. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.5 Goal: Marketing and educational materials that are developed in appropriate formats that meet the needs of the client, and that are available in a timely manner, and in adequate supply.

10.5.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify key enrollment information such as member and provider handbooks, description of the benefit package, member services, provider directories, specialty/ancillary services, etc. The workplan shall describe how the plan will determine the needs of the client, e.g., reading level, languages, enhanced methods of availability such as Braille, audio, video, etc., and that the materials are meeting the needs on an ongoing basis. The workplan shall include specific activities that it will utilize to determine the types/methods of communication required, e.g., census data, surveys of client population, work with advocate groups, etc., the appropriateness of the materials, e.g., focus groups, subcontracts for translations and interpreters, etc., and the designated staff responsible for the activity.

The initial workplan shall address the plan's proposed activities for the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that includes the requirement for review by the Department, and an anticipated distribution plan.

10.5.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the

plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.5.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.6 Goal: Enhanced activities that promote a woman's early access to the full array of pregnancy-related services to a pregnant woman and her unborn/newborn.

10.6.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall describe the plan's benefits, programs, case management, member services and follow-up care for a pregnant woman and her unborn/newborn. The workplace should describe how the plan will incorporate the following, and similar, unique aspects of Nebraska Medicaid:

(a) Where pregnancy-related services (e.g., prenatal, delivery and postpartum care) may require "open-ended" referrals for the mother for pregnancy-related services by the plan to a PCP specializing in obstetrics/gynecology (i.e., in situations where the mother receives services through the "eligibility" of her unborn who is enrolled with a pediatrician);

(b) The splitting of claims between the traditional fee-for-service system and the plan, if the actual enrollment of the pregnant mother/unborn occurs during the time period the package of pregnancy-related services are provided;

(c) Multiple births; and

(d) Out-of-network deliveries.

The workplan shall also include a description of what measures the plan will utilize to ensure the following, and similar, situations:

(a) Early entry into prenatal care;

(b) Assistance for the pregnant woman to overcome various obstacles to obtaining prenatal care (e.g., lack of transportation, communication/language barriers, deafness, cultural barriers such as the woman cannot have a male examiner; and child care issues);

(c) Prenatal preventative health education programs or materials plan; and

(d) Referral system for, and provision of, non-obstetric problems that may develop during the course of the pregnancy, e.g., other medical conditions, mental health and substance abuse problems, social issues such as homelessness, domestic violence, etc.

The workplan shall include specific activities, educational or other marketing approaches that will be utilized and the designated staff responsible for the activity.

The initial workplan shall address the plan's proposed activities for the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that includes the requirement for review by the Department, and an anticipated distribution plan.

10.6.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan should also include information on the service utilization, member services/case management, and any measurable data on the effect of the plan's outreach/provision of services on the outcome of the pregnancy.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.6.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to promote early access to a full array of pregnancy-related services on a quarterly basis.

10.7 Goal: Operationalizing NHC procedures that allow for the inclusion of legal representatives, advocates or HHS staff to participate in the client's overall enrollment and NHC activities, as appropriate.

10.7.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify how the plan will incorporate inclusion of legal representatives, advocates and HHS staff in the NHC activities. The plan shall identify its training protocols for staff and providers on this provision and how the

plan will evaluate the effectiveness of the requirement, and the plan's ability to work with the Medicaid client and others who are legally, or otherwise, responsible for assisting the client in the coordination of care and problem-resolution. The plan should identify staff responsible for coordinating such efforts

The workplan shall identify any business protocols that address the above requirement and the extent to which the plan will go to work with the Medicaid population in resolving issues, and coordinating efforts with others involved with the client. The plan should also address applicable policies on confidentiality, case management, member services and how it will incorporate the concepts into its daily operations.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.7.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.7.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work the plan to meet this requirement.

10.8 Goal: Operationalizing the NHC's methods of client notification and verification to assist the client and provider in establishing managed care participation.

10.8.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall demonstrate how the plan shall inform staff and providers of the Department's notification process to ensure that staff and providers are able to verify eligibility at the time of service. The plan shall include any proposed methods of educating the client about managed care eligibility and the importance of carrying the Identification Document as verification of managed care participation. Describe the plan and provider's ability to access eligibility either through the plan's procedures or by utilizing the Department's automated NMES line. Include routine and non-routine procedures the client should follow to access both the plan and PCP, and how this will be communicated to the client and provider.

The workplan shall demonstrate how the plan shall inform staff and providers of the Department's notification process to ensure that staff and providers are able to verify

eligibility at the time of service. The plan shall include any proposed methods of educating the client about managed care eligibility and the importance of carrying the Identification Document as verification of managed care participation. Describe the plan and provider's ability to access eligibility either through the plan's procedures or by utilizing the Department's automated NMES line. Include routine and non-routine procedures the client should follow to access both the plan and PCP, and how this will be communicated to the client and provider.

The workplan shall also demonstrate the plan's procedure and method of notification to the client on the approval, denial or reduction of a service.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.8.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues. The plan shall report the number of calls received from clients who are attempting to verify enrollment with the plan, as well as the number of times the providers report that client's are not providing proper verification at the time of service delivery.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.8.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.9 Goal: The technological capability to receive and process the Enrollment Report (in the form of a data file) and have the information available by the first of the enrollment month.

10.9.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan should describe the plan's technical understanding of the enrollment report file layout, and how it will systematically process the information. The plan shall identify staff who will be responsible for receiving and implementing the data, and how the information will be shared with staff and providers.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.9.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues. The plan shall report the number of calls received from clients who are attempting to verify enrollment with the plan, as well as the number of times the providers report that client's are not providing proper verification at the time of service delivery.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The Department shall evaluate the plan's ability to provide the necessary resources to utilize the enrollment file layout and make the information available in a timely manner, given the Department's production schedule. The workplan shall address problems related to the enrollment file layout, and the plan's ability to resolve these problems effectively and in a timely manner.

10.9.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.10 Goal: Operationalizing the procedure where a client who is hospitalized is enrolled or disenrolled with managed care, creating a situation of shared responsibility between the plan and the Department, for a defined period of time.

10.10.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify how the plan will incorporate the Department's hospitalization procedures into business operations. The plan shall identify any training protocols, and staff responsible for coordinating the above issue with the Department.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.10.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and

approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations, both in care management and claims payment. The plan shall be required to report hospitalization-related activities in the quarterly report.

10.10.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.11 Goal: Enhanced operational procedures to deal with clients who have been auto-assigned and who come into the NHC uneducated about managed care.

10.11.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall demonstrate the plan's understanding of the auto-assignment process and the impact it shall have on member services, case management, and service utilization. The plan should describe any training protocols that it shall provide to staff and providers, and how it will coordinate the continuity of care issues for auto-assigned clients. The plan should also demonstrate its efforts to educate the client and coordinate related issues to ensure the client is not disadvantaged by the auto-assignment process.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.11.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues. The plan shall report the number of calls received from clients or providers with issues related to this requirement.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations, both in care management and claims payment. The plan shall be required to report hospitalization-related activities in the quarterly report.

10.11.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.12 Goal: Operationalizing the NHC's procedure for PCP/Plan-Requested Transfers.

10.12.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall demonstrate the plan's understanding of the Transfer Procedures, and how the plan will implement the process. The plan should include any training or business protocols it will utilize to incorporate the transfer procedures into daily operations.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.12.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues, and to report transfer activity on a quarterly basis.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

10.12.3 Minimum Requirement: The plan shall be considered In compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

10.13 Goal: Operationalizing the procedure for nursing facility admission, and coordinating the level of care determination and financial responsibility with the Department.

10.13.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall demonstrate the plan's understanding of the nursing facility procedures, and how the plan will implement the process. The plan shall include any training or business protocols it will utilize to incorporate the nursing facility procedures into daily operations.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999. The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

10.13.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues, and to report transfer activity on a quarterly basis.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations, both in care management and claims payment. The plan shall be required to report hospitalization-related activities in the quarterly report.

10.13.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

11.0 PLAN RESPONSIBILITIES - INTERFACE WITH ENROLLMENT BROKER SERVICES

11.0 Introduction: Enrollment Broker Services (EBS) provided for the NHC in the Designated Coverage Areas are provided through a contractual arrangement with the Lincoln/Lancaster County Health Department (i.e., Access Medicaid). Information contained in Article XI of this contract is primarily informational, but also identifies the interface that is required between the plan and the EBS. EBS requirements for Public Health Nursing (PHN) and related services are not intended to replace any of the Primary (PCP)/plan responsibilities; but, rather, to augment the overall coordination of care issues for the NHC client.

11.1 Overview of Enrollment Broker Services: The EBS is a contracted entity that completes the following NHC functions: initial client marketing, education, and outreach; enrollment activities; health assessment; health services coordination; public health nursing; Helpline services; client advocacy; and EBS satisfaction surveys. The EBS is required by contract to develop protocols, plans, and procedures to implement these functions. These protocols, plans, and procedures shall be prior approved by the Department.

11.1.1 EBS Functions: The EBS shall assist the client in the process of enrolling in the NHC and selecting his/her PCP/plan and in accessing and understanding all facets of the NHC. The EBS shall also assist in the transfer and waiver of enrollment/disenrollment of clients and in the coordination of support services throughout the provider network. EBS shall assist and support clients in their communities to achieve maximum health status and to fully participate as informed clients in the NHC.

11.1.2 Translation and Accommodations: The EBS shall provide access to translation and interpreter services and shall ensure that all necessary accommodations are made to ensure that the special needs of the NHC clients are addressed throughout the enrollment process.

11.2 Distribution of Informational and Marketing Materials: The EBS shall be responsible for the distribution of informational and marketing materials to the NHC client, as it relates to enrollment activities. The EBS shall ensure that any informational and marketing materials is completed in coordination with the plan and the Department and meet the following guidelines:

(a) All materials shall be developed in a manner that ensures a thorough understanding by the client and that a client's special needs (i.e., language barriers, disabilities, cultural/socioeconomic sensitivity, competency, reading level, etc.) are appropriately addressed;

(b) All printed materials must be in an easily understandable format at a fourth grade reading level;

(c) All methods of communication (e.g., written, oral, audio, video, interpreted, etc.) may be used;

(d) Materials on all NHC service components shall be distributed equitably and without bias to any particular plan;

(e) Materials shall be available in sufficient amounts for all clients and other interested parties to ensure client access to information;

(f) Materials shall clearly state information about NHC, ensuring the client has adequate information to make an " informed" selection and include all required information;

(g) Materials shall be reviewed and approved by the Department, i.e., designated staff and the Medicaid Advisory Group;

(h) The EBS shall provide documentation to the Department that the development of all orientation/educational materials included an external advisory review and that the external advisory group included clients and/or client advocates;

(i) The EBS shall review materials to ensure current and accurate representation of all NHC services, plan information and related Nebraska Medical Assistance Program (NMAP) services;

(j) The EBS shall update information as changes occur or as areas of concern/information are identified by the Department, plans, or clients;

(k) The EBS shall ensure that any client-specific information is treated confidentially;

(l) Publish or otherwise release client information only with the prior written approval of the Department;

(m) All materials shall clearly state that all necessary accommodations shall be made to assist the client; and

(n) Continue to explore innovative ways to communicate to the clients with special needs, e.g., a videotape that includes a persons signing, with closed captions and in other languages.

11.3 Enrollment Activities: The EBS shall complete the following enrollment activities for mandatory clients (and also for potential mandatory clients, if requested), in coordination with the plan and the Department:

(a) Educate clients concerning the full range of Medicaid benefits, including all NHC options and covered services, including -

(1) A general explanation of NHC;

(2) Mandatory and excluded groups of clients;

(3) The purpose/benefits of managed care, including the " medical home" concept and the difference between fee-for-service and managed care;

(4) The role of the PCP;

(5) An explanation of how the client shall choose a PCP/plan;

(6) An explanation of auto-assignment;

(7) An explanation that the PCP/plan shall either provide or approve services included in the Basic Benefits Package;

(8) An explanation of the HEALTH CHECK (EPSDT) program, if age appropriate, including information on how to access screening services (health, dental, vision, and hearing);

(9) An explanation of services not covered under NHC and how the client may access these services;

(10) An explanation of those services which do not require any PCP/plan approval or prior authorization (e.g., family planning and emergency services);

(11) An explanation of the 24-hour Helpline and the availability of the TTY/TDD and interpreter services;

(12) An explanation of transfers and disenrollment;

(13) An explanation of client/provider rights and responsibilities;

(14) An explanation of the complaint/grievance/appeal/process; and

(15) An explanation of how to be an effective health care consumer;

(b) Provide the client with brochures, written materials, etc., explaining the NHC that are easily understood by the client, and developed in ways appropriate to meet the needs of the client;

(c) Provide an assessment of health and social needs;

(d) Assist the client or his/her legal representative in choosing a PCP/plan, based on a process, approved by the Department, that protects the client's right to choose and that is equitable and without bias to any particular plan; identifying any existing relationships with health care practitioners; and emphasizing the importance of prompt selection of a PCP/plan. The client is free to choose a PCP/plan from all available options; however, the EBS shall screen for the following and similar information;

(1) Geographical location of the client, his/her legal representative, significant family member(s), foster parent, child welfare worker, etc.

(2) Access (e.g., transportation issues);

(3) Medical need/provider specialty based on information provided by the client;

(4) Established utilization patterns based on information provided by the client;

(5) Family groupings;

(6) Current medical relationships, e.g., the client has received services from an enrolled PCP;

(7) Number of physicians in the geographical areas;

(8) Number of available slots per PCP; and

(9) Unique features about the PCP, e.g., skilled in foreign/sign language, preferences by a client's particular culture or religious beliefs, etc.

(e) The EBS shall assist the client in the resolution of problems relating to the accessibility of health care delivery, including but not limited to, identifying transportation service issues, language barriers, and handicap accessibility issues; and

(f) The EBS shall enter the PCP/plan selection on the Managed Care File. The Department shall notify the plan of all enrollments on the monthly enrollment report.

11.3.1 Plan-Specific Printed Materials: The EBS shall provide the client with a provider directory and other information on covered services in the Basic Benefits Package (and also to potential mandatory clients, if requested).

11.3.2 Client-Requested Materials: The EBS shall also coordinate the following with the plan if the following, or similar, information is requested by the mandatory client or potential mandatory client:

(a) Client rights and responsibilities;

(b) Identity, location, qualifications and availability of health care providers that participate with the plan;

(c) Complaint, grievance and appeal procedures; and

(d) Information on covered items and services.

11.4 Enrollment Outreach: The EBS shall be responsible for the activities and associated marketing, informational, and educational materials which precede selection or assignment of a client to a PCP/plan. Enrollment outreach activities include, but are not limited to,

mailings, follow-up, and orientations, conducted by telephone or in person, as appropriate to meet the needs of the client, e.g., use of an interpreter, etc. Outreach shall continue after auto-assignment, if the client did not have the opportunity to benefit from education about the NHC.

11.5 Health Assessment: The Health Assessment is designed to establish the client's basic health status and assist the EBS in identifying administrative enrollment, health and social issues. If utilized over time, it shall be used as a mechanism for the Department to establish the impact of managed care on the overall health status of the Medicaid population enrolled in NHC.

11.5.1 Administration of the Health Assessment: The EBS shall administer the health assessment in a manner that is sensitive and responsive to each client's individual circumstances.

11.5.2 Health Assessment Results: The EBS shall review specified results of the health assessment with the client to enable the client to make an informed choice regarding a PCP/plan to best meet his/her needs. Information from the health assessment shall be sent to the client's plan who is responsible for sharing the information with the PCP for purposes of medical management of the client by the PCP/plan.

11.5.3 Health Assessment Indicators and Referrals: The status of indicators specified in the EBS protocols shall be discussed with the client. As medically indicated, the EBS shall immediately refer clients with certain indicators to the client's PCP if enrollment in the NHC is effective, and to available health services if the client is not enrolled in NHC. The EBS shall contact the PCP regarding the referral and work with the client to ensure follow-through with the referral.

11.6 Public Health Nursing (PHN): A major component of the NHC is Public Health Nursing (PHN). PHN shall provide a client-centered approach to achieve the maximum health status possible for each client enrolled in NHC and to ensure that the client experiences a seamless integrated health care delivery system that includes a variety of community resources known to affect health status outcomes.

11.6.1 Referrals to the PHN: Referrals to the PHN may be initiated by the PCP/plan, Department, or other appropriate individuals.

11.6.2 PHN as a Resource to the PCP/Plan: The EBS is a resource to the PCP/plan and the client. The PHN component of the EBS provides a public health component to the delivery of health care services, and assists the PCP/plan when the client's environment interferes with a positive medical outcome. In providing this function, the EBS shall not perform home health or personal care aide activities.

11.6.3 PHN Coordination with PCP: The PHN component works as an extension of the PCP to improve the health and wellness of the client, but only after the PCP/plan has exercised his/her responsibilities.

11.7 Reasons for Referral: The EBS shall be responsible for promoting effective utilization of health resources to enable clients to better manage their own health care and to build community support systems by encouraging health, wellness, and a positive relationship with

the PCP/plan. Intervention by the EBS may occur in, but is not limited to, the following situations:

(a) When the client is not effectively accessing or utilizing the NHC system, the EBS may assist the client through advocacy, assessment, issues-oriented liaison activities, and education;

(b) Serving as a resource to the PCP/plan in identifying other state and community-based agencies that provide vital health and social supports for clients;

(c) Assisting the PCP/plan in complying with federal requirements for HEALTH CHECK (EPSDT) services; and

(d) Assisting the PCP/plan in providing services to high-risk pregnant women and their infants, taking into account age, education, alcohol or drug use/abuse, weight, medical and psychosocial conditions and the need to ensure access to needed medical, social, educational and other services.

11.8 PHN Outreach: When determined necessary, the EBS shall schedule visits with the client/family. The visits may be performed at the Health and Human Services (HHS) local office, in the client's home, other mutually agreeable site, or by telephone, whichever is most expeditious and convenient to the client and the EBS.

11.9 PHN Needs Assessment: The EBS shall conduct an assessment of needs for each referral which shall include, but is not limited to -

(a) Medical conditions(s), illness and treatment history, current medications and treatment plans, assessment of compliance with prescribed treatments, and family medical histories;

(b) Previous medical providers and hospitalizations, both for assessment purposes and to ensure that appropriate records and information are transferred to a new provider and that proper client authorization for the transfer is obtained;

(c) The specific community and/or public services with which the client had existing or recent relationships; the existence of case manager(s) and/or recent relationships; and/or service case workers;

(d) A detailed family/individual assessment of medical, supportive, social needs, and behaviors which place the client at risk for disease, injury, or other barriers to health care, employment, or daily living requirements; and

(e) Provide specific follow-up education and referral/service planning regarding the specific issues, if any, which were raised by the PCP/plan at the time of the referral to the EBS.

11.10 Documentation of Requests for PHN Services: The EBS shall document each request for PHN. The EBS documentation shall include, but is not limited to, the following:

(a) The nature or extent of the problem;

(b) Attempts to resolve/triage the problem;

(c) Referrals or other evaluation already made on the client's behalf;

(d) An explanation of what action was requested and time frames; and

(e) Source of referral.

11.10.1 PCP Follow-up: The EBS shall contact the PCP within five working days of the request.

11.10.2 Development of a Care Plan: The PHN, in partnership with the client, PCP/plan, or other pertinent entities, shall develop a plan to address the needs identified in the assessment process to promote optimum levels of health and ensure the client is able to receive maximum benefits from medical intervention.

11.11 Coordination with the PCP/Plan and Healthcare Delivery Team: The PHN shall, in partnership with the client, coordinate with the PCP/plan information obtained regarding health status, lifestyle, and other information relevant to case management of the individual client.

11.11.1 PCP/Plan Consultation: The PHN shall present written reports and documentation to the PCP/plan, as appropriate, and consult in person or by telephone with the PCP/plan regarding the client according to established EBS protocols.

11.12 HEALTH CHECK (EPSDT) Outreach: HEALTH CHECK (EPSDT) services is a priority for the NHC and, as such, shall be emphasized whenever appropriate and feasible with families who have children age 20 and the younger. The EBS shall work cooperatively with the PCP/plan to:

(a) Promote preventive health care and encourage eligible children to receive HEALTH CHECK (EPSDT) screening examinations according to the American Academy of Pediatrics periodicity schedule. Target groups to focus on are -

(1) Newly Medicaid eligible children;

(2) Other Medicaid eligible children who have not had timely HEALTH CHECK (EPSDT) examinations; and

(3) Children from birth to their second birthday, particularly infants and toddlers that may need immunizations, lead level testing, developmental testing and hearing testing;

(b) Receive referrals from the PCP/plan regarding children who missed screening appointments without cancellation based on guidelines established by the Department; contact with families to determine barriers to

care, to assist in rescheduling appointments, and to counsel families about keeping appointments;

(c) Receive referrals from the PCP/plan regarding children who are screened, referred for further diagnosis and/or treatment and who did not follow-up with treatment services per guidelines set forth by the Department; contact families to determine barriers to care and to assist the families in initiating care in a manner that is supportive to the family;

(d) Encourage all newly eligible children who have not had a screening examination to make an appointment for a health and dental screening. The family shall be counseled on the importance of health supervision and regular checkups and shall be assisted in removing barriers to care;

(e) If requested, assist families with appointment scheduling with the PCP and dentist, if the child is age three or older; and

(f) Complete a second contact or send a reminder if an examination is not scheduled in 30 days. The reason for declination shall be documented.

11.13 Helpline: The EBS shall establish a telephone Helpline to provide basic answers to client questions regarding the NHC. The Helpline shall be staffed and equipped in appropriate technologies, e.g., TTY/TDD and language services, etc., to accommodate the client needs. The Helpline shall:

(a) Respond to clients' questions about the NHC and facilitate referrals to community resources, as appropriate;

(b) Make reasonable efforts to resolve or otherwise respond to NHC issues raised by clients or providers, including but not limited to:

(1) Inquiries from NHC providers regarding the policies, procedures, and protocols of the NHC, as defined and provided by the Department;

(2) Problems related to services provided under the NHC. Resolution of this type of problem may require referral to the Department;

(c) Facilitate the resolution of nonclinical services disputes between clients and PCP/plan, in accordance with policy, procedures, and protocols of the NHC as defined and provided by the Department. This may include, but is not limited to:

(1) Unreasonable waiting periods of appointments;

(2) Dissatisfaction with specialty referrals;

(3) Unsatisfactory client/provider relationships;

(4) Unsatisfactory client/provider relationships; and

(d) Provide a mechanism for reporting complaints and client or PCP requests for transfers and disenrollments.

11.13.1 Helpline Availability: The Helpline shall be available to all NHC clients, PCP/plans and others. The EBS shall provide information to the Department and the plan on Helpline activities.

11.14 Client Satisfaction: The EBS shall conduct client satisfaction surveys to evaluate the availability, quality and outcome of care from the client's perspective. The surveys shall identify and allow investigation of sources of dissatisfaction, permit action to be taken on findings and provide information to the Department and the PCP/plan. Satisfaction surveys shall focus on, but is not limited to, the following areas and shall be conducted at a minimum of not less than annually:

(a) Access to care;

(b) Utilization;

(c) Coordination of care;

(d) Continuity of care;

(e) Health education;

(f) Quality of care;

(g) Understanding of cultural differences; and

(h) Respect afforded the client and/or family.

11.14.1 Survey Method/Results: The survey instrument shall be administered as a questionnaire (either in person, by mail or in other appropriate forms to meet the client's needs), a telephone survey, focus groups and complaint logs. The EBS shall submit reports on the surveys according to Departmental requirements. Survey results will be shared with the plans, according to Department guidelines.

11.14.2 Survey Tool: The EBS shall develop or utilize already existing tools and develop a program with measurable goals and objectives. The Department shall approve the process and survey tool prior to its use, and will work cooperatively with the plan and EBS in developing the client satisfaction survey process.

11.15 Client Advocacy: The EBS shall be required to provide general advocacy services on behalf of clients. This component of the EBS shall be incorporated into the entire array of activities performed by the EBS.

11.15.1 Advocacy Functions: Handling of client and provider complaints is a primary function of the EBS and requires a client advocacy approach to the resolution. The EBS is responsible for the components of client advocacy, including but not limited to:

(a) Receipt of client complaints from all sources. The EBS shall respond to all client complaints according to guidelines established by the Department. The EBS shall attempt to resolve any conflicts with the PCP/plan when in the client's best interest. EBS shall maintain a client complaint log, which shall be approved by the Department. All client complaints shall be handled by the EBS and resolved in the least restrictive manner possible;

(b) When complaints cannot be resolved through the EBS, the EBS shall advise the client of his/her rights and responsibilities to pursue complaints, and grievances, including requesting a fair hearing. The EBS shall also inform the client of the availability of the State Ombudsman Office; and

(c) Appeals to the Department regarding any adverse decision made by the Department or its designee may be formally requested through the local HHS office. The EBS shall advise the client of the appeal process available under 465 NAC, when complaints cannot be resolved.

11.16 Lock-In Procedures: Lock-in is a method used by the Department to limit the medical services of a client who has been determined to be abusing or overutilizing services provided by the Department without infringing on the client's choice of providers.

11.16.1 Enrollment for a "Lock-In" Client: The client shall complete standard enrollment activities for the NHC. Enrollment into the NHC may change the client's previous lock-in categories of pharmacy, primary physician and hospital, or identify through the EBS/PHN that a new lock-in status for the client is recommended. The EBS shall complete the necessary information pertaining to a client's lock-in status, at the time of enrollment.

11.16.2 Transfer for a "Lock-in" Client: A "lock-in" client may transfer from one PCP/plan to another pursuant to this contract.

12.0 GOALS/MEASURES - INTERFACE WITH ENROLLMENT BROKER SERVICES

12.1 Goal: Coordination between the Department, the plan and the EBS for the provision of easy-to-understand plan-related materials that are available to the EBS in a timely manner to ensure an effective, informative enrollment with the client.

12.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall describe the plan's overall marketing approach, i.e., proposed materials, development and printing requirements and timelines. The plan shall include a description of the materials that it intends to distribute to the client prior to enrollment, during enrollment and after enrollment The plan shall indicate its ability to have materials ready for distribution by July, 1999, and staff responsible for these activities with the Department and the EBS.

The workplan shall describe how the plan proposes to work in a productive manner with the EBS and the Department in the development of the enrollment-related materials and compliance with the Department's the NHC Marketing Criteria Procedure Guide and the Departmental Review Procedures.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

12.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The Department shall also evaluate the plan's marketing effort, quality of materials, the ability of the plan to provide quick turnaround on revisions and maintain accurate information.

12.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC

policy and procedure . The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

12.2 Goal: Utilize the Health Assessment Information to provide improved care management, member services and coordination of health issues with the client and PCP.

12.2.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall describe the plan's ability to receive the health assessment information , and how the plan proposes to utilize the information provided, e.g., outreach, coordination with member services, case management, disease state management, coordination with the PCP, client education, etc.

The workplan shall identify staff responsible for the receipt, operationalization of the information and a flowchart describing how the information will be shared among the staff and providers. The plan should also identify how it will communicate with the EBS on the receipt of the information, and coordination of case management issues.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.2.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The plan shall be required to report the activities associated with the receipt of the health assessment information and any outcomes resulting from its use in the quarterly report.

12.2.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure, The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

12.3 Goal:. Incorporate the PHN functions in the plan's operational activities to ensure enhanced coordination of healthcare and social issues for the Medicaid client.

12.3.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities

The workplan shall describe how the plan will coordinate the PHN functions with the PCP and specialty/ancillary providers in the plan's network, as well as the plan's member services and case management components.

The workplan shall describe the plan's ability to coordinate activities with the PHN, and how the plan proposes to utilize the information provided, e.g., outreach, coordination with member services, case management, disease state management, coordination with the PCP, client education, etc.

The workplan shall identify staff responsible for the receipt, operationalization of the information and a flowchart describing how the information will be shared among the staff and providers. The plan should also identify how it will communicate with the EBS on the receipt of the information, and coordination of case management issues.

The workplan shall demonstrate the plan's understanding of the PHN concept and how it will train staff and providers in operationalizing the coordination of healthcare and social issues with the PHN.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.3.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The plan shall be required to report the activities associated with the PHN functions and any outcomes resulting from its use in the quarterly report.

12.3.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

12.4 Goal: Coordinated effort between the plan and the EBS in complying with HEALTH CHECK (EPSDT) requirements.

12.4.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities The workplan shall describe the plan's activities in meeting the HEALTH CHECK (EPSDT) requirements and how the plan will coordinate the required screening, diagnostic and treatment activities with the EBS.

The workplan shall demonstrate the plan's understanding of the HEALTH CHECK (EPSDT) requirements and how it will train staff and providers. Utilizing the EBS as an extension of the PCP/plan responsibilities in this area, how will the plan operationalize the EBS functions. The plan shall identify staff responsible for implementing and monitoring the HEALTH CHECK (EPSDT) activities and how the plan will evaluate the success of their HEALTH CHECK (EPSDT) program.

The plan should identify how it will coordinate HEALTH CHECK (EPSDT) activities with the EBS and provide required data to the Department.

The workplan shall describe how the plan will coordinate the HEALTH CHECK (EPSDT) requirements with the PCP and specialty/ancillary providers in the plan's network, as well as the plan's member services and case management components.

The workplan shall describe the plan's ability to coordinate activities with the EBS, and how the plan proposes to utilize the information provided, e.g., outreach, coordination with member services, case management, disease state management, coordination with the PCP, client education, etc.

The workplan shall identify staff responsible for the receipt, operationalization of the information and a flowchart describing how the information will be shared among the staff and providers. The plan should also identify how it will communicate with the EBS on the receipt of the information, and coordination of case management issues.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.4.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The plan shall be required to report the activities associated with the EBS functions and any outcomes resulting from its use in the quarterly report.

12.4.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

The Department shall evaluate the plan's ability to conceptualize and operationalize the HEALTH CHECK (EPSDT)requirements. The plan will be required to report HEALTH CHECK (EPSDT) activities and outcomes in the quarterly report.

12.5 Goal: Resolution of Helpline issues reported to the plan by the EBS, and the incorporation of the Helpline functions into the plan's operational activities to ensure enhanced coordination of healthcare and social issues for the Medicaid client.

12.5.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities

The workplan shall describe how the plan will coordinate the Helpline functions with the PCP and specialty/ancillary providers in the plan's network, as well as the plan's member services and case management components.

The workplan shall describe the plan's ability to coordinate activities with the Helpline staff, and how the plan proposes to utilize the information provided, e.g., outreach, coordination with member services, case management, coordination with the PCP, client education, complaint and grievances, etc.

The workplan shall identify staff responsible for the receipt, operationalization of the information and a flowchart describing how the information will be shared among the staff and providers. The plan should also identify how it will communicate with the EBS on the receipt of the information, and coordination of case management issues.

The workplan shall demonstrate the plan's understanding of the Helpline concept and how it will train staff and providers in operationalizing the coordination of healthcare and social issues with the EBS.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.5.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The plan shall be required to report the activities associated with the Helpline functions and any outcomes resulting from its use in the quarterly report.

12.5.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

12.6 Goal: Incorporation of the principles of " client advocacy" in the plan's operation and management activities to promote a coordination of healthcare and social issues for the Medicaid client.

12.6.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities

The workplan shall describe how the plan will incorporate client advocacy into its operation and management activities, and how it will promote such principles with the PCP and specialty/ancillary providers in the plan's network, as well as the plan's member services and case management components.

The workplan shall describe the plan's ability to coordinate activities with the EBS in carrying out the advocacy functions, and how the plan proposes to utilize the information provided by the EBS, e.g., outreach, coordination with member services, case management, coordination with the PCP, client education, complaint and grievances, etc.

The workplan shall identify staff responsible for the receipt, operationalization of the information and a flowchart describing how the information will be shared among the staff and providers. The plan should also identify how it will communicate with the EBS on the receipt of the information, and coordination of case management issues.

The workplan shall demonstrate the plan's understanding of the advocacy principles, and how it will train staff and providers in operationalizing the coordination of healthcare and social issues with the EBS.

The workplan shall describe how issues will be identified, tracked and monitored for timely resolution and coordination between the plan, the PCP, EBS and the Department.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.6.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

12.6.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department shall evaluate the plan based on its understanding of the concept of client advocacy, the unique needs of the Medicaid population, and how it incorporates the requirement into daily operations. The plan will be required to report all related activities in the quarterly report. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to promote client advocacy on a quarterly basis.

12.7 Goal: Coordination with the EBS and the Department to identify and facilitate the "lock-in" of a client. Operationalizing the procedure when a client is "locked-in" to a particular provider.

12.7.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities

The workplan shall identify how the plan will incorporate the Department's lock-in procedures into business operations. The plan shall identify any training protocols, and staff responsible for coordinating the above issue with the Department.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

12.7.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations, both in care management and claims payment. The plan shall be required to report lock-in related activities in the quarterly report.

12.7.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

ARTICLE XIII

13.0 PLAN RESPONSIBILITIES - THE PROVISION OF THE BASIC BENEFITS PACKAGE

13.1 Introduction: Article XIII sets forth the responsibilities of the plan in delivering the Basic Benefits Package to the Nebraska Health Connection (NHC) client.

13.2 Governing NHC Regulations: In developing a program for the delivery of the Basic Benefits Package, and all related aspects of the NHC, pursuant to this contract, the plan shall incorporate the information contained in this contract, 471 NAC, which defines in detail the minimum service provisions required for the NHC under the Nebraska Medical Assistance Program (NMAP), and 482 NAC, which defines the policy and procedures for the NHC. Titles 471 and 482 shall be revised to agree with the requirements contained in this contract and be effective July 1, 1999.

13.3 Plan Relationship to PCP: While the PCP is responsible for providing the client a "medical home" and ensuring appropriate health care services, the plan, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the NHC programmatic requirements.

13.3.1 Functionality of the PCP: The client chooses or is assigned to a Primary Care Physician (PCP). The PCP is the physician who provides a "medical home" for the client and is responsible for referrals for all medically necessary services. PCPs may participate in one or all of the HMOs, and/or in the Primary Care Case Management (PCCM) Network, which is addressed under a separate contract. The PCP shall be a Medicaid-enrolled provider. A specialty care physician may function in an extended capacity with the PCP in certain circumstances with plan approval pursuant to this contract.

13.3.2 Types of Providers: To participate in the NHC, a PCP shall be a primary care physician whose primary expertise is in family practice; general practice; pediatrics; internal medicine; or obstetrics/gynecology, as identified as the primary specialty in the Department's Provider File System. These five specialties shall be available for the client to choose as his/her PCP in either the HMO or PCCM Network.

13.4 Teaching Clinics: For teaching clinics, the client shall choose the facility's attending physician in the teaching clinic as the PCP, even though the clinic's resident actually provides care to the client. This attending physician shall supervise and sign off on all medical care provided to the client.

13.5 Designated Specialty Care Physicians: An appropriate specialist shall be allowed to function in an extended capacity with the PCP for clients with chronic conditions requiring specialty care.

13.5.1 EBS Facilitated Request: The following procedures apply when a client, PCP/plan, or other person on behalf of the client requests such as arrangement pursuant to this contract:

(a) The requester shall contact the EBS and provide documentation, in the form of a letter, of the reason(s) for the request;

(b) The EBS shall review the documentation and conduct any additional inquiry to clearly establish the reason(s) for request;

(c) The EBS shall submit the request to the plan within two days of the request;

(d) The plan shall approve or deny the request within five working days and respond to the EBS, along with written justification if the plan denies the request, and alternatives for the client to consider such as expanded consultative services;

(e) The EBS shall inform the Department of the plan decision;

(f) The Department shall notify the client of the decision. The plan shall notify the PCP and specialist; and

(g) The plan shall monitor the effectiveness of the PCP and specialist in providing continuity of care for the client.

13.5.2 Department Initiated Request: If the request is initiated by or made to the Department, the request will be forwarded to the EBS within five working days.

13.5.3 Plan Responsibility: The request for a designated specialty care physician to function as a PCP shall be the decision of the plan. The following shall be considered by the plan in accommodating the client's needs:

(a) An "open referral" between the PCP and specialist, and shall monitor the overall continuity of care. The PCP for the client does not change, only the shared responsibility and ease of referral patterns between the PCP and the designated specialist, under the plan's oversight; and

(b) Providing consultative services to the PCP and/or specialist for certain experience-sensitive conditions, e.g., HIV/AIDS.

13.5.4 Enhanced Functions of the PCP Specialist: The designated specialty care physician shall have enhanced functions for clients with special health care needs designated upon review and concurrence of the Primary Care Physician (PCP), the specialist and the plan. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc.

13.5.5 Case-Specific Provision: While this provision is written as an alternative to be utilized by the plan, the Department has a general expectation that the plan shall provide all necessary specialty and consultative services as a matter of practice. This provision is to facilitate a more complex, case-specific, approach for a client with special medical needs.

13.5.6 Case-Specific Reporting: The plan shall report all such "facilitative" arrangements to the Department.

13.6 Limit on Number of Enrollees: Under the contractual responsibilities of the plan, the plan shall ensure that the PCP is allowed to care for no more than 1500 Medicaid clients. The plan share also ensure that when a PCP employs one or more physician extenders (i.e., nurse practitioners, physician assistants, certified nurse midwives, second-year and third-year residents), the PCP shall care for no more than an additional 500 clients, for a total of 2000 Medicaid clients. This allowable limit is referred to as PCP "slots" . The plan shall maintain accurate information about the number of allowable slots for each PCP in the Department's Provider Network File.

13.7 PCP Qualifications and Responsibilities: Under the contractual responsibilities of the plan, the plan shall ensure that the PCP:

(a) Be a Medicaid-enrolled physician and agree to comply with all pertinent Medicaid regulations pursuant to 471 NAC;

(b) Sign a contract with the plan as a PCP which explains the PCP's responsibilities and compliance with the following NHC requirements;

(1) Treat NHC clients in the same manner as other patients;

(2) Provide the Basic Benefits Package per 471 NAC to all clients who choose or are assigned to the PCP's practice according to the Enrollment Report and comply with all requirements for referral management, prior-authorization and prior-approval;

(3) Coordinate appropriate referrals when medically necessary to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services, and ensure that such services are provided by Medicaid-enrolled providers;

(4) As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs clients such as accommodations for the deaf and hard of hearing, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.;

(5) Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to live voice (an employee of the PCP or an

answering service) or an answering machine that shall immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;

(6) Not refuse an assignment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;

(7) Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTY/TDD and language services, etc., to accommodate the client's special needs;

(8) Request transfer of the client to another PCP only for the reasons pursuant to this contract, and continue to be responsible for the client as a patient until another PCP is chosen or assigned;

(9) Notify the plan in a timely manner so that an Interim PCP can be assigned if disenrolling from participation in the NHC;

(10) Maintain a medical record for each client and comply with the requirement to coordinate the transfer of medical record information if the client changes to another PCP;

(11) Utilize the Enrollment Broker Services and Public Health Nursing components of the NHC pursuant to this contract, as appropriate;

(12) Maintain a communication network that provides necessary information to any MH/SA services provider as frequently as necessary based on the client's needs. Many MH/SA services require concurrent and related medical services, and vice versa, such as, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package and the MH/SA services, and in sharing and coordinating case management activities, is shared by providers in both areas.

The PCP shall coordinate the provision, authorization, payment and the continuity of care, and the plan shall monitor overall coordination between these two service areas, i.e., medical/surgical and MH/SA. The plan shall ensure that the PCP is knowledgeable about the MH/SA and other similar services and ensure that appropriate referrals are made to meet the needs of the client;

(13) Communicate with agencies such as, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccine for Children, communications

regarding management of infectious or notifiable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;

(14) Comply with all disease notification laws in the State;

(15) Provide information to the Department as required;

(16) Inform clients about all treatment options, regardless of cost or whether such services are covered by the Nebraska Medical Assistance Program (NMAP); and

(17) Provide accurate information to the plan in a timely manner, so that PCP information can be exchanged with the Department, via the Provider Network File .

13.8 PCP Disenrollment: The plan shall allow the PCP to voluntarily disenroll from participation in the NHC. If the PCP is disenrolled from NHC, s/he may remain active as a Medicaid provider on a fee-for-service basis for clients not participating in the NHC, if all Department regulations continue to be met. The disenrollment shall be reported by the plan on the Provider Network File.

13.9 Interim PCP Assignment: The plan shall be responsible for assigning an Interim PCP in the following situations:

(a) The PCP has terminated his/her participation with the plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care; or

(b) The PCP is still participating with the plan but is not participating at a specific location, i.e., change in location only.

13.9.1 Plan Responsibilities: The plan shall be responsible for the following:

(a) Ensuring a smooth transition for the client through the assignment of an "Interim PCP" ; and

(b) Immediately notifying the client, by mail or by telephone, that the client is being temporarily assigned to another PCP within the same plan and that the new PCP shall be responsible for meeting the client's health care needs until a transfer can be completed/activated by the EBS.

13.9.2 Activating the Interim PCP: The actual transfer of the client from the client's current PCP to the plan-designated Interim PCP will be accomplished by the Plan and the Department via an exchange of information that will systematically be loaded into the Managed Care File by the Department. This information will be provided by the Plan to the Department at the time the client letter is sent out. The Department shall process the transfer immediately upon receipt of the information the first month possible, given system cutoff.

13.9.3 Client Choice: The client can change the "interim" transfer at any time, by following standard transfer procedures.

13.9.4 PCP Change in Location: If a PCP changes location, the plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location.

13.9.5 PCP Moves Out-of-State: If the PCP has actually moved out-of-state, and the PCP is no longer within coverage distance to the client, the plan shall treat the PCP as a terminated PCP.

13.9.6 Notification on NMES: The Department, based on a termination date on the Provider Network File, shall automatically change the name of the PCP on the NHC Identification (ID) Document and on the Nebraska Medical Eligibility System (NMES) to indicate "Call your plan" . This shall allow the plan to work with the client in applying the interim PCP regulations, if applicable.

13.9.7 Change in Provider Number: In situations where a provider changes his/her Medicaid provider number, the plan is not required to notify the client. The Department shall automatically make the change from the old number to the new number, as soon as the number change is identified, i.e., on a nightly basis.

13.9.8 Plan Restriction: If a plan becomes aware of a client's desire to change the PCP and/or plan, the plan shall refer the client to the EBS, and may assist the client in contacting the EBS, but shall not be involved in the client's choice.

13.10 Provision of the Basic Benefits Package: The plan shall provide the Basic Benefits Package according to all governing regulations and ensure the Basic Benefits Package are provided to clients in the same manner (i.e., in terms of timeliness, amount, duration, quality and scope) as those services provided to the non-managed care Medicaid client;

13.11 Sufficient Numbers of PCP Slots: The plan shall maintain sufficient numbers of PCP slots to ensure adequate access to clients enrolled in the NHC.

13.11.1 Provider Network Enrollment File: The plan shall notify the Department via the Provider Network Enrollment File prior to the effective date of any PCP change whenever possible and if required, notify the client of an interim PCP pursuant to this contract.

13.12 Medicaid-Enrolled Providers: The plan shall only use providers enrolled in Nebraska Medical Assistance Program (NMAP) to provide the Basic Benefits Package under the NHC pursuant to this contract.

13.13 Adequate Mix of Providers: The plan shall provide an appropriate range of services and access to preventive and primary care services in the designated coverage areas, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such a cultural diversity and sensitivity, languages, accessibility to clients with mental, physical and communication disabilities, etc.

13.14 Provision of Services Restriction: The plan shall only provide services directly or arrange for services through subcontractors.

13.15 Compliance with PCP Requirements: The plan shall ensure that the PCPs participating in the plan's network comply with all PCP requirements pursuant to this contract.

13.16 Client's Choice: The plan shall accept the client's choice of PCP/plan.

13.17 Case Management: The plan shall provide case management.

13.18 Informational Materials: The plan shall comply with the following:

13.18.1 Client Information: The plan shall provide the following to each client enrolled with its plan:

(a) A client handbook that is easy to understand and includes policies and procedures to access care;

(b) Other Information about the NHC benefits that is easy to understand; and

(c) A comprehensive list of physicians, specialists and ancillary service providers; and

13.18.2. Departmental Review and Approval: The plan shall comply with the following:

(a) Request the Department's review and approval of all general marketing and informational materials prior to its implementation or distribution pursuant to this contract;

(b) Ensure that marketing materials do not contain any false or potentially misleading information, in a manner that does not confuse or defraud either the Department or client;

(c) Ensure that marketing materials are available for the client population being served in the designated coverage areas; and

(d) Comply with federal requirements for provision of information including accurate oral and written information sufficient for the client to make an informed decision about treatment options.

13.19 Prohibition of Direct Solicitation: The plan shall refrain from performing any direct solicitation to individual Medicaid clients, and comply with the following:

(a) Avoid offering other insurance products as an inducement to enroll; and

(b) Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing.

13.20 QA/QI Activities: The plan shall comply with the Department's continuous Quality Assurance/Quality Improvement activities, provide health services that meet the Department's quality standards, and comply with all requests for reports and data consistent with peer review privilege, to ensure that QA/QI performance measures are met pursuant to this contract.

13.21 ADA Requirements: The plan shall comply with all requirements of the Americans with Disabilities Act (ADA), and ensure:

(a) Appropriate accommodations are made for clients with special needs; and

(b) That PCPs and specialists are equipped in appropriate technologies, e.g., TTY/TDD and language services, or are skilled in various languages and areas of cultural diversity/sensitivity, and/or the network is appropriately staffed to ensure an adequate selection for those clients who have special cultural, religious or other special requests.

13.22 Provision of Services: The plan shall coordinate activities with the Department, other NHC contractors, and other providers for services outside the Basic Benefits Package, as appropriate, to meet the needs of the client, and ensure that systems are in place to promote well managed patient care, including, but not limited to -

(a) Management and integration of health care through the PCP, and coordination of care issues with other providers outside the plan or with for services not included in the Basic Benefits Package (e.g., MH/SA services, Pharmacy, Dental Services, etc.), or for services that require additional Departmental authorization (e.g., sterilization exceptions for age and consent period requirements, abortions, experimental or investigational treatment, HEALTH CHECK (EPSDT) treatment services not covered by Nebraska Medicaid, Transplants (except corneal), Nursing Facility Services, etc.;

(b) Required referral/prior authorization requirements for medically necessary specialty and ancillary services;

(c) Provision of or arrangement for emergency medical services, 24 hours per day, seven days per week, including an education process to help assure that clients know where and how to obtain medically necessary care in emergency situations;

(d) Unrestricted access to "protected" services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;

(e) Clearly identified expectations for the PCPs, subcontractors and any other service providers participating in the client's managed care, and documentation of that care for quality assurance/quality improvement purposes;

(f) Retention of records and other documentation during the period of Contracting, and for three (3) years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other

legal action involving the records is started before or during the original three (3) year period ends; and

(g) Adequate policy on the distribution of the client's medical records if a client changes from one PCP to another, or from one plan to another.

The requirement of this section to "coordinate" with others in the provision of care outside the Basic Benefits Package does not mean the Plan in any way assumes any responsibility for that care, or any acts, omissions or qualifications of anyone or any entity assuming the responsibility for the client's care.

13.23 Laboratories: The plan shall, whenever possible, use State-designated laboratories to ensure that lab results that involve infectious or notifiable diseases or diseases for which there are registries maintained by Federal, State and Local public health agencies.

13.23.1 CLIA Requirements: The laboratories utilized by the plan shall comply with the Clinical Laboratory Improvement Act (CLIA).

13.24 Public Health Initiatives: The plan shall work cooperatively with the public health agencies to share appropriate service data, participate in other similar preventative and data collection initiatives that may be promoted by the Department and public health agencies, and comply with all noticeable requirements and "good practices" .

13.25 Advance Directives: The plan shall comply with regulations providing for advance directives.

13.26 Discrimination: The plan shall not refuse an enrollment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition.

13.27 Subcontractors: The plan shall require that all subcontractors meet the same requirements as are in effect for the contractor that are appropriate to the service or activity delegated under the subcontract.

13.28 Member Services: The plan shall provide member services.

13.29 Certificate of Authority: The plans shall maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;

13.30 Physician Incentive Program (PIP): The plan shall provide for a PIP only if:

(a) No specific payment is made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a client;

(b) The plan provides information on its PIP to any Medicaid client, upon request, and that the plan includes a statement on its marketing materials that discloses the client's right to adequate and timely information to related physician incentives;

(c) The plan does not have PIPs placing a physician or physician group at substantial financial risk for the cost of services;

(d) Where appropriate, the physician or physician group provides adequate stop-loss protection to the individual physicians; and

(e) Where appropriate, the plan conducts client surveys.

13.31 Applicable Regulations: The plan shall comply with all applicable state and federal regulations, such as assisted suicide; appropriate use of funds/profits, mental health parity, and the Hyde Amendment.

13.32 Provider Discrimination: The plan shall refrain from discrimination against providers based upon licensing.

13.33 Barred Individuals or Entities: The plan shall refrain from hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare.

13.34 Medical Specialists: The plan shall provide for an adequate numbers of medical specialists to meet the needs of its members. Clients with chronic or severe medical conditions, e.g., HIV/AIDS, may be allowed to go directly to a qualified specialist within the plan's network pursuant to Section 13.5.3 and 13.5.4.

13.35 Treatment Options: The plan shall ensure that PCPs inform clients about all treatment options, regardless of cost or whether such services are covered by the plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does not require a plan to cover counseling or referral if it objects on moral or religious grounds and makes available information on its policies to clients who are enrolled with the plan, or who may enroll with the plan, within ninety (90) days of a policy change regarding such counseling or referral services.

13.36 Client Rights: The plan shall provide written notice to the client of any adverse action (i.e., denial or reduction) regarding the provision of services that complies with all federal and state requirements. The plan shall also allow clients to challenge decisions to deny, limit or terminate coverage of services. Clients shall be allowed to file complaints, grievances and appeals pursuant to this contract.

13.37 HIPPA Requirements: The plans shall comply with the Maternity and Mental Health Requirements in the Health Insurance and Portability Act (HIPPA) of 1996 in that the maternity length of stay and mental health parity requirements in HIPPA requires that coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than forty-eight hours (48) for both the mother and newborn child, and that the health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than ninety-six (96) hours for both the mother and newborn child.

13.38 Surety Bond: The plan shall provide assurances that any amount expended for the direct provision of home health care services provided by the plan will be covered by the appropriate surety bond.

13.39 Fraud and Abuse: The plan will cooperate with the Department and report all nonprivileged fraud and abuse information to the Department. "Fraud and Abuse" refers to the violation of state or federal criminal or civil statutes imposing penalties for specific violations related to the provision of Medicaid services.

13.40 Timely Provider Payments: The plan shall comply with the provider payment provisions pursuant to this contract.

13.41 Contract: The plan shall sign a contract with the Department and comply with all contract requirements and related responsibilities specified by the Department in the overall operation of the NHC, and any other activities deemed appropriate by the Department that are supported in regulations and/or contractual amendments.

13.42 HEALTH CHECK (EPSDT): The plan shall develop a program to ensure the delivery of HEALTH CHECK (i.e., Early and Periodic Screening, Diagnosis and Treatment or EPSDT services).

13.42.1 Priority: The plan shall emphasize HEALTH CHECK (EPSDT) as a priority for the NHC, whenever appropriate and feasible with families who have children age twenty (20) and the younger.

13.42.2 Member Contact: The plan shall contact HEALTH CHECK (EPSDT) eligible children within sixty (60) days of enrollment and encourage them to make an appointment for a health and dental screening.

13.42.3 Required Components: The plan shall emphasize the required health screening, including medical, vision, hearing and dental screening pursuant to this contract.

13.42.4 Plan Requirement: The plan shall counsel the family on the importance of health supervision and regular check-ups and assist in removing barriers to care, and if necessary, assist families with appointment scheduling and transportation. At a minimum, efforts shall include:

(a) HEALTH CHECK (EPSDT) Screening: The plan shall provide HEALTH CHECK (EPSDT) services pursuant to 471 NAC;

(1) The plan shall outreach to HEALTH CHECK (EPSDT) eligible children who need to be scheduled for HEALTH CHECK (EPSDT) examinations. Targeted groups are -

a. Newly Medicaid-eligible and other children who have not had a timely HEALTH CHECK (EPSDT) examination;

b. Children who have been identified as not having ever been screened or not having received HEALTH CHECK (EPSDT)

services within established timelines based on the periodicity schedule; and

c. Children from birth to the second birthday, particularly infants and toddlers that may need immunizations, lead level testing, developmental testing and hearing testing.

(2) The plan shall contact the EBS regarding-

a. Screening appointments missed without cancellation to determine the barriers to care, to assist in rescheduling the appointment, and to counsel the family about keeping appointments; and

b. Screening results from a referral for treatment and the client who does not follow up with treatment services as identified by the plan.

(3) The plan shall assist the PCP to establish a recall system for HEALTH CHECK (EPSDT) examinations. The recall systems may provide notification through phone call or post card. The plan may substitute their recall system in place of the PCP's;

(4) The plan shall use continuous quality improvement methods to achieve a performance goal of HEALTH CHECK (EPSDT) screens at the recommended participation rate, pursuant to the contract; and

(5) The plan shall provide HEALTH CHECK (EPSDT) screens at a recommended participation rate of at least five (5) percent greater than the rate by age reported in the HCFA-416 Annual EPSDT Report for FY1996 for the first contract year and shall increase at a rate of five (5) percent per year thereafter until eighty (80) percent or the most current HCFA participation goal in the aggregate is reached. Measurement will be done according to the methodology of the HCFA-416, based on encounter data.

If the resulting plan participation is less than the expected performance standard, the Department shall recoup an amount equal to the average payment for a health screening for the proportion of clients who did not receive a screen.

If participation exceeds the goal an incentive will be provided. Screening and referral rates will be publicly disclosed for each plan.

(b) If a client requests a HEALTH CHECK (EPSDT) screen for the initial screen, the plan shall to provide the screening examination(s) within sixty (60) days. Subsequent screening exams (including vision and hearing, medical and referral for dental) shall be provided according to the periodicity schedule, or an interperiodic examination if appropriate. The minimum schedule of health screening examinations is the "Recommendations for Preventive Pediatric Health Care" published by the American Academy of Pediatrics.

(c) The plan shall be responsible for the administration of immunizations pursuant to this contract. All PCPs shall participate in the Vaccine for Children (VFC) program to provide childhood immunizations to Medicaid eligible children. The VFC program was established to ensure that children will have access to childhood immunizations and the protection they provide. The requirements of the VFC program administered will be reported with the appropriate procedure code and A52″ modifier to identify them as VFC vaccine immunizations. Vaccine not available through the VFC program, but recommended and published by the Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics shall be provided and reimbursed by the plan to the PCP. The plan shall promote increasing immunization levels to reach the State's Healthy 2000 immunization level goals.

Immunization administration for VFC vaccines shall be paid by the plan to any public health provider whether s/he is in the plan's network or not.

(d) The PCP/plan shall take a proactive approach to ensure clients obtain HEALTH CHECK (EPSDT) screening services and medically necessary diagnosis and treatment services. A proactive approach includes:

(1) Written notification and phone protocols if possible for upcoming or missed appointments within a set period of time;

(2) Protocols for conducting outreach with non-compliant members;

(3) Outreach and follow-up to children with special health needs, e.g., children in foster care, pregnant adolescents;

(4) Provision of demographic information to public health agencies when HEALTH CHECK (EPSDT) screening identifies children with elevated blood lead levels (EBLL); and

(5) Referrals to public health agencies for environmental assessments and caregiver education services for children with lead poisoning.

(e) Medically necessary treatment will be provided according to 471 NAC. Treatment services also include rehabilitative and habilitative services for HEALTH CHECK (EPSDT) eligible children. That is, diagnosis and treatment, covered by the Nebraska Medical Assistance Program (NMAP), federally defined and medically necessary, to treat, prevent or ameliorate a condition; to promote growth and development; to attain or maintain functional status; or prevent deterioration. The plan must provide information and referral in addressing social, educational, and other health needs as requested. Refer requests for treatment not covered by NMAP to the Department.

(f) Throughout the contract term, the plan shall participate in the NHC Quality Assurance Plan's ongoing maternal and child health-related activities, including those supporting the HHS regulations and licensure's grant under

maternal and child health programs and activities. Cooperate with the Department's Title V, Maternal Child Health Program (MCHP), to include:

(1) Training on new public health measures and standards;

(2) Working together to develop strategies to reach hard to reach and high risk populations;

(3) Contracting with Title V providers and Title X clinics, whenever feasible, for evaluations and treatment services;

(4) Sharing medical information with the Medically Handicapped Children's Program (MHCP) for children receiving services through MHCP and the plan;

(5) Developing arrangements with MHCP regarding specialty care through MHCP team clinics in the best interests of the child;

(6) Coordinating with other services, e.g., WIC, PART H school-based services, as appropriate;

(7) Cooperating with public health agencies who have identified children with abnormal lead levels. The plan will provide lead screening and blood lead testing according to the Center for Disease Control (CDC) and Health Care Financing Administration (HCFA) requirements; provide information to PCPs regarding the provision of blood lead screening and testing; provide information regarding coverage of environmental investigation; encourage collaboration and communication with public health lead prevention programs; and utilize and reimburse laboratories under contract with public health lead prevention programs to perform blood level testing. The plans shall not require a PCP/plan approval to receive reimbursement for specimens sent to the laboratories by public health agencies; and

(8) Coordinating with public health immunization clinics regarding immunization reporting.

(g) The plan shall use specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for adult specialists, e.g., pediatric cardiologist for children with congenital heart defects.

13.43 Third Party Liability (TPL) Requirements: The plan shall utilize a cost avoidance methodology whenever there is a verified third party resource (TPR) within the following parameters:

(a) The plan, its subcontractors or providers, shall actively pursue, collect, and retain any monies from third party payers for the usual and customary charges on covered services to clients covered under the plan's Contract with the Department for NHC except when the amount of reimbursement the

plan can reasonably expect to receive is less than the estimated cost of recovery; and

(b) The plan, its subcontractors or providers, may, at their sole discretion, compromise a claim against a third party payer, or may elect not to pursue the claim if they determine it is not cost effective to do so. The Department shall provide whatever assistance or assignments, as are necessary, to aid in the plan's collection efforts. Any recoveries by the plan shall not affect continued payment of capitation for that client as long as the client remains enrolled in NHC.

(c) The Department has assigned to the plan, or its subcontractors or providers, all rights to recover payments from third parties as provided by state law, in its contract with the plan. TPR refers to any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a Medicaid client. Under federal law, the Department is required to identify legally liable third parties and treat verified TPR as a resource of the client. The plan, its subcontractors or its providers shall not pursue collection from the client but directly from the liable third party payers, except as allowed in 468 NAC, 469 NAC, and 477 NAC.

(d) TPR includes, but is not limited to:

(1) Private health insurance;

(2) Casualty insurance;

(3) Employment-related group health insurance;

(4) Group health plans defined under section 607(1) of ERISA;

(5) Workers' Compensation; and

(6) Other federal program unless excluded by statute, such as Indian Health Service programs and Migrant Health programs.

(e) The plan shall:

(1) Take responsibility for pursuing TPR for clients in the above categories;

(2) Make reasonable attempts to identify TPR within its existing resources, but the primary responsibility for identifying TPR and communicating that information to the plan is with the Department or its designee. The Department shall retain the responsibility for collecting the TPR of Medicare Part A and/or Part B, medical support from absent parents, and first party probate estate recoveries;

(3) Provide available information to, and cooperate with, the Department in its effort to collect those resources;

(4) To track its TPR recoveries for its enrolled clients and to report these recoveries to the Department using the guidelines listed below. The Department shall supply the plan with available TPR information for enrolled clients on a monthly basis;

(5) Maintain records of all third party recoveries and report this recovery activity to the Department on a monthly basis in a form and manner agreeable to both parties. The plan's recovery activity report shall detail any recovery activity taken by the plan against any of the TPR. Activity shall include, but is not limited to:

a. Filing a lien,

b. Submitting a bill,

c. Receiving payment,

d. Working with a client's legal representative, and/or

e. Receiving a denial from a TPR;

(6) On claims paid by the plan, the plan shall submit claims to health insurers within 60 days following notification of an available TPR;

(7) In a liability situation, the plan shall file a lien if lawfully permitted, within thirty days following notification of the available liability resource; and

(8) The plan shall notify the Department of clients who refuse to assist the plan and the Department in enforcing TPR recovery.

13.44 Basic Benefits Package General Provisions: The plan shall comply with the requirements of 471 NAC pursuant to this contract, unless specifically waived by the Department. The PCP/plan shall apply the same guidelines for determining coverage of services for the NHC client as the Department applies for other Medicaid clients. Actual provision of a service included in the Basic Benefits Package must be based on whether the service could have been covered under the Nebraska Medical Assistance Program on a fee-for-service basis under Title 471 NAC, pursuant to this contract.

13.44.1 Copayments: Copayments are not required for clients enrolled in NHC, with the exception of prescription drugs or other Medicaid-covered services not included in the Basis Benefits Package. Copayments are not required for Mental Health/Substance Abuse (MH/SA) services for clients enrolled in the NHC, except for services not included in the MH/SA Package.

13.44.2 Services Requiring Prior-Authorization by the Department: The PCP/plan shall provide or approve all services in the Basic Benefits Package. In addition to the PCP/plan provision/approval, the following services shall be prior authorized by the Department:

(a) HEALTH CHECK (EPSDT) treatment services not covered by the State Plan pursuant to 471 NAC;

(b) Abortions pursuant to 471 NAC;

(c) Transplants pursuant to this contract; and

(d) Sterilization Exceptions pursuant to 471 NAC.

13.44.3 Unrestricted Services: The plan shall not require authorization for family planning services, emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services. The plan shall allow the client to access these services from any Medicaid-enrolled provider s/he chooses, and is not limited to providers within the plan's network. The plan shall allow the client to access these services without a referral, even if the plan contracts with Medicaid to provide these services.

13.44.4 Emergency Services: The plan shall provide all covered emergency services 24 hours per day, seven days per week, and shall not limit these services to plan-affiliated providers. The plan shall allow the client to access these services from any Medicaid-enrolled provider s/he chooses, and is not limited to providers within the plan's network. The plan shall allow the client to access these services without a referral, even if the plan provides these services.

13.44.5 Emergency Room Charges: The plan shall reimburse providers, network and out-of-network, for appropriate medical screening performed during an emergency room visit. The payment of claims to out-of-network providers are subject to the timeliness of provider payments pursuant to this contact.

13.45 Services in the Basic Benefits Package: Pursuant to this contract, services included in the Basic Benefits Package are -

(a) Inpatient hospital services (471 NAC 10-000);

(b) Outpatient hospital services (471 NAC 10-000);

(c) Clinical and anatomical laboratory services (471 NAC 10-000 and 18-000), excluding laboratory services related to Mental Health/Substance Abuse (MH/SA), effective January 1, 2000;

(d) Radiology services (471 NAC 10-000 and 18-000), excluding radiology and anesthesiology services related to MH/SA effective January 1, 2000;

(e) HEALTH CHECK (EPSDT) services (471 NAC 33-000 and Section 13.42 of this Contract);

(f) Physician services, including nurse practitioner services, certified nurse midwife services, physician assistant services and anesthesia services including Certified Registered Nurse Anesthetist (471 NAC 18-000 and 29-000), excluding anesthesia for MH/SA;

(g) Home health agency services (471 NAC 9-000). This does not include non-home agency approved Personal care aide services under 471 NAC 15-000);

(h) Private duty nursing services (471 NAC 13-000);

(i) Therapy services (physical therapy -471 NAC 17-000, occupational therapy-471 NAC 14-000, and speech pathology and audiology-471 NAC 23-000);

(j) Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (471 NAC 7-000 and 8-000);

(k) Podiatry services (471 NAC 19-000);

(l) Chiropractic services (471 NAC 5-000);

(m) Ambulance services (471 NAC 4-000 and 10-000);

(n) Medical transportation services (471 NAC 27-000);

(o) Visual services (471 NAC 24-000);

(p) Family Planning services (See 471 NAC 18-000 and Section 13.47 of this contract);

(q) Emergency services (See 471 NAC 10-000 and Section 13.48 of this contract);

(r) Transitional MH/SA services (See 471 NAC 20-000, 32-000 and 13.49 of this contract);

(s) Federally Quality Health Center (FQHC), Rural Health or Tribal Clinic services (See 471 NAC 11-000, 29-000, 34-000 and Section 13.50 of this contract);

(t) Certified Nurse Midwife services (See 471 NAC 18-000 and Section 13.51 of this contract);

(u) Skilled/Rehabilitative and Transitional Nursing Facility services (See 471 NAC 12-000 and 13-000, and Section 9.20 of this contract);

(w) Transitional Hospitalization services (See 471 NAC 10-000, Section 9.13, 9.18 and 9.19 of this contract); and

(x) Transitional Transplantation services (See 471 NAC 10-000 and Section 9.18 of this contract).

13.45.1 Assurances: The plan shall provide the following assurances, if requested by the Department:

(a) That the services above represents covered services under the Nebraska Medical Assistance Program (NMAP);

(b) That the client has access to all services;

(c) That the services shall be provided in the same amount, duration and scope pursuant to this contract;

(e) That the client shall receive necessary services when the care and services provided are medically necessary;

(f) That the services provided to the client are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client; and

(g) Any value added non-medically necessary services will not be reimbursed in the capitation fee or separately paid for by the Department.

13.46 NHC Excluded Services: The following Medicaid-coverable services are excluded from the NHC Basic Benefits Package and are not the responsibility of the plan:

(a) Pharmacy Services (471 NAC 16-000);

(b) Nursing Facility Services - custodial level of care (See 471 NAC 12-000 and 9.20 of this contract);

(c) ICF/MR services (See 471 NAC 31-000);

(d) Home and community based waiver services (See Title 480 NAC);

(e) School-based services covered under Medicaid in Public Schools (See 471 NAC 25-000). The plans are still required to operate a program to improve the quality of and access to health care services for children and adolescents through coordination with school-based services;

(f) Optional targeted case management services (See Title 480 NAC);

(g) Mental Health/Substance Abuse (MH/SA) Services (See 471 NAC 20-000 and 32-000), except as addressed in Section 13.49 of this contract);

(h) Dental (See 471 NAC 6-000);

(i) Laboratory and anesthesia services related to MH/SA (See 471 NAC 20-000 and 32-000); and

(j) Non-Home Health Agency Approved Personal Care Aide Services (471 NAC 15-000).

13.46.1 Access to Excluded Services: These services are paid on a fee-for-service basis. Clients shall access these services under the NMAP (i.e., 471 NAC or 480). However, provision of these services by the Department may require referral, management and coordination by the client's PCP, if the client is enrolled in the NHC. For all Medicaid-covered services, the PCP/plan shall coordinate the client's care to promote continuity of care for the client. The plan and EBS shall inform the client of the availability of these services and how to access them.

13.47 Family Planning Services: Approval by the client's PCP/plan is not required for family planning services. The EBS shall inform NHC clients that their freedom of choice for family planning services is not restricted to a plan provider under NHC but must use a Medicaid enrolled provider.

13.47.1 Family Planning Services Defined: Family planning services are services to prevent or delay pregnancy, including counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. This includes tubal ligations and vasectomy. Treatment for sexually transmitted diseases (STD) is to be reimbursed by the plans in the same manner as family planning services, without referral or authorizations by the PCP/plan. STD includes but is not limited to Chlamydia, Gonorrhea and Syphilis.

This does not include hysterectomies, other procedures performed for a medical reason, such as removal of an intrauterine device due to infection, or abortions.

See Addendum A.

13.47.2 Payment: The plan shall pay family planning services even if the provider is not part of the plan's network. Such payment shall not exceed the current Medicaid fee schedule. Department will hold plan harmless for all claims against plan which allege plan negligence in connection with such services.

13.48 Emergency Services: Prior-approval by the client's PCP/plan is not required for receipt of emergency services. The EBS shall inform NHC clients that PCP/plan approval of emergency services is not required and shall educate clients on the definition of an "emergency medical condition" , how to appropriately access emergency services, and encourage the client to contact the PCP/plan before accessing emergency services

13.48.1 Payment of Emergency Services Provided to NHC Clients: The plan has no obligation to pay for emergency services unless the provider of the emergency services submits a bill within ninety (90) calendar days of the date services were provided.

If the plan has reasonable basis to believe that any covered services that are claimed to be emergency services were not in fact emergency services, payment may be denied for the services; provided that, within ninety (90) calendar days of receipt of a claim for payment -

(a) The provider of the services is notified of the decision to deny payment, the basis for that decision, and the provider's right to appeal that decision by requesting a hearing (See 482 NAC); and

(b) The client is notified of the decision to deny payment, the basis for that decision, and the client's right to appeal (See 482 NAC).

13.48.2 Triage or Screening Fee: The plan shall provide a triage or medical screening fee to determine if a medical emergency exists.

13.48.3 Payment Subject to Appeal Decision: The plan shall comply with and implement any Departmental hearing decision, subject to any further rights to appeal.

13.48.4 Emergency Medical Condition Defined: An emergency medical condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy;

(b) Serious impairment to such person's bodily functions; or

(c) Serious impairment of any bodily organ or part of such person.

13.49 Mental Health/Substance Abuse (MH/SA) Coordination Issues: The following rules apply when coordination of services is required between the medical/surgical plan responsible for the Basic Benefits Package and the MH/SA plan responsible for the MH/SA services, as addressed by the Department in regulations governing both components of the NHC. In situations where the client isn't participating in both components of the NHC, the associated service is coordinated with the Nebraska Medicaid Assistance Program on a fee-for-service basis.

13.49.1 Emergency Room Services for MH/SA Services: Emergency room services provided to a client who is participating in the MH/SA component of the NHC is the responsibility of the client's medical/surgical plan regardless of the client's final or principle diagnosis.

At the time a MH/SA provider initiates an evaluation and/or treatment for the client, the medical/surgical plan is no longer responsible for MH/SA related service. Authorization for MH/SA services from that point forward must be obtained from the MH/SA plan.

13.49.2 Admissions for 24-HourObservation:

When a client who is participating in the MH/SA component of the NHC is admitted to an acute care (i.e., medical/surgical) facility as an outpatient for 24-hour observation (for purposes of a MH/SA diagnosis), the MH/SA plan is responsible for payment of the observation stay. Authorization for the admission must be obtained from the MH/SA plan.

The MH/SA plan is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the client and determines that the client does not have a MH/SA diagnosis. Authorization for medical/surgical services from that point forward must be obtained from the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

13.49.3 Chemical Detoxification Services and Substance Abuse Treatment: Chemical detoxification is a covered service for clients of any age. Authorization for hospital admissions must be obtained from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Substance abuse treatment services are covered for Medicaid-eligible clients age 20 and the younger only. Allowable substance abuse services for a client must be authorized by the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

13.49.4 History and Physical (H&P) Exams for Inpatient Admissions for MH/SA Services: The H&P completed for an inpatient admission for MH/SA services is not the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC. The physician completing the H&P must obtain authorization from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Inpatient MH/SA services provided to clients participating in the MH/SA component of the NHC in a freestanding or hospital-based residential treatment center (RTC) treatment group home are the responsibility of the MH/SA plan. H&Ps provided to NHC clients for these allowable services are not responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

13.49.5 Ambulance Services for NHC Clients Receiving MH/SA Treatment Services: Emergency medical transportation, regardless of diagnosis or condition is the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

All other medically necessary ambulance services are the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Non-ambulance and non-emergency medical transportation for MH/SA services is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

13.49.6 Injections Associated with MH/SA Services: Injections of psychotropic drugs, such as Haldol and Prolixin, in an outpatient setting, are the responsibility of the client's MH/SA plan, if the client is participating in the MH/SA component of the NHC.

13.49.7 Effective January 1, 2000 Lab, X-Ray and Anesthesiology Associated with MH/SA Services: Services associated with the treatment of MH/SA services and authorized by a MH/SA provider participating in the MH/SA plan's network, such as lab fees, x-ray charges and the administration of anesthesiology, is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC, effective January 1, 2000.

13.50 Federally Qualified Health Centers (FQHC): Each plan shall contract with any FQHC located within the designated coverage area or otherwise arrange for the provision of FQHC services. If an FQHC is reimbursed by the plan on a fee-for-service basis, it cannot pay less for those services than it pays other providers. FQHC's that elect to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the FQHC requests reasonable cost reimbursement, the plan must reimburse the FQHC at the same rate it reimburses its other subcontractors. A plan that contracts with a FQHC shall report to the Department the total amount paid to each FQHC as specified in the contract. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

13.50.1 Client Choice: In the NHC, the client chooses to participate with the FQHC by selecting the physician as his/her PCP.

13.50.2 Availability of FQHC Facilities: Currently, the following facilities are in the designated coverage areas and meet the definition of an FQHC:

(a) Nebraska Urban Indian Health Center - Lincoln; and

(b) Charles Drew - Omaha.

The Panhandle Community Services Health Center in Gering is also considered a FQHC but is not included in the designated coverage areas.

13.50.3 Rural Health Clinics: No Rural Health Clinics exist in the designated coverage areas.

The same reasonable efforts that are applied to the FQHC, apply to the Rural Health Clinics.

13.50.4 Tribal Clinics: The following are considered clinics/hospitals under tribal authority:

(a) Ponca Health and Wellness Dental Clinic in Omaha;

(b) Winnebago Dental Health Clinic in Winnebago;

(c) Carl T. Curtis Health Center in Macy; and

(d) Santee Health Center in Niobrara.

13.51 Certified Nurse Midwife Services: A certified nurse midwife may contract directly with the plan or the client must be informed in writing that the services are available outside the plan on a fee-for-service basis.

13.52 Payment for Services: The following provisions apply for payment of services provided by the plan.

13.52.1 Enrollment Report: On or before the first day of the enrollment, the Department shall provide to each plan a monthly enrollment report that lists all enrolled and disenrolled clients for the enrollment month. This report shall be used as the basis for the monthly capitation

payments to the plan. The plan shall be responsible for payment of all services in the Basic Benefits Package provided to clients listed on the enrollment report generated for the month of coverage. Any discrepancies between the client's NHC Identification (ID) Document or any identification issued by the plan and the enrollment report must be reported to the Department for resolution. The plan shall continue to provide and authorize services for the client until the discrepancy is resolved. If an eligible client is not listed on the enrollment report, the Department shall be responsible for all medical expenses pursuant to this contract.

13.52.2 Coverage for Pregnant Women/Newborns: The plan is responsible for providing pregnancy-related services pursuant to this contract for both the mother and unborn/newborn considering the following parameters:

(a) Pregnant Woman and Unborn/Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs and for the unborn/newborn from the month of expected birth until disenrollment occurs. Payment to the plan shall be made for the month(s) of enrollment for the pregnant woman and the unborn/newborn until disenrollment occurs.

(b) Only the Unborn/Newborn is Medicaid Eligible: Coverage is provided for the pregnant woman through the eligibility/enrollment of the unborn/newborn from the month of enrollment until disenrollment occurs. Coverage for the mother and newborn is provided for the month of expected birth through the month in which the 60th day following the month of expected birth occurs. Coverage for only the newborn continues past the 60-day postpartum period as long as the newborn remains eligible and enrolled. Payments to the plan shall be made for the month(s) of enrollment and/or coverage for the pregnant woman and the unborn/newborn until disenrollment occurs.

13.53 Payment for NHC Services: The Department shall pay a monthly capitation fee to the plan for each enrolled client for each month of NHC coverage. The monthly capitation fee includes payment for all services in the Basic Benefits Package.

The plan shall provide payment to providers for services rendered on a timely basis, consistent with Medicaid claims payments procedures, unless the health care provider and organization agree to an alternative payment schedule pursuant to 8.46 of this contract.

Payment to the plan shall be considered payment in full for all services included in the Basic Benefits Package. No additional payment shall be requested of the Department or the client.

The capitation rates in Addendum B are actuarially determined and are based on geographic location, eligibility category, gender, age and type of services. The Department shall adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any changes in the Upper Payment Limit, Medicaid fee-for-service (FFS) rates, or in instances where an error or omission in the calculation of the rates has been identified. At no time shall the rates be adjusted prior to the end of contract year 2. Rates will be set for each two (2) year period and negotiated for each subsequent two-year period.

The total amount paid to the plan shall not exceed the Upper Payment Limit (UPL) of what it would have cost the Department to provide the same services under the FFS to an actuarially equivalent population.

13.53.1 Recoupments/Reconciliation: The Department shall not normally recoup payments from the plan. However, in situations where payments are made incorrectly, the Department shall work with the plan to identify the discrepancy and shall recoup/reconcile such payments pursuant to Section 9.11.3 of this contract.

13.53.2 Billing the Client: The plan or any provider shall not bill the client for services in the NHC benefits package while the client is enrolled in the NHC.

A provider of service may only bill the client pursuant to 471 NAC.

The MH/SA plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. Whether the MH/SA plan is responsible to pay the provider is determined by the agreement the MH/SA plan has with that provider. In some cases, the provider may not get paid.

Note: The plan shall not pay a non-Medicaid enrolled provider for a Medicaid-covered service.

ARTICLE XIV

14.0 GOALS/MEASURES - THE PROVISION OF THE BASIC BENEFITS PACKAGE

14.1 Goal: To maintain all appropriate licensures and insurance coverage, business and liability insurance coverage, declarations of affiliations and compliance with performance bond/insolvency requirements.

14.1.1 Initial Measure: To verify by July, 1999 that the plan has a current certificate of state or federal authority to operate as a Health Maintenance Organization (HMO) in Nebraska, or other appropriate licensure. The plan shall also verify current business and liability insurance coverage, affiliations and compliance with insolvency requirements.

The plan shall also indicate the status of any accreditation or certification by any independent third party organizations, i.e., National Committee on Quality Assurance or Joint Commission on Healthcare Organizations.

14.1.1 Ongoing Measure: To maintain at all times that the plan has a current certificate of state or federal authority to operate as a Health Maintenance Organization (HMO) in Nebraska, or other appropriate licensure. The plan shall also verify current business and liability insurance coverage.

14.1.2 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the plan meets all requirements and reports them annually, and whenever there is a change in status.

14.2 Goal: An adequate panel of Primary Care Physicians (PCPs) to ensure that each client in the NHC has access to a "medical home" , and that the plan can adequately provide or arrange access for the client to all the services included in the Basic Benefits Package through an adequate network of specialists, hospitals and other ancillary service providers.

14.2.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The plan shall submit a complete listing of its panel of physicians who meet the definition of a PCP. The plan shall also submit all specialty, hospital and ancillary service providers who actually have a contract with the plan, or who have provided the plan with a letter of intent to contact with the plan effective July, 1999. At a minimum, the listing shall include the name of the provider, area(s) of specialty, and location. Other information is encouraged and may be helpful during the enrollment process.

The plan shall provide this information in the form of a printed directory that will be available July, 1999.

Include a description of how the plan intends to keep the directory current, the ongoing development and printing requirements, and staff responsible for maintaining the integrity of the directory.

The workplan shall identify how the plan will determine what is " adequate" and ensure that the client has access to medically necessary services through network development and credentialling activities.

The plan shall also include a sample of all provider-type agreements, describe its recruitment, credentialling and monitoring activities to demonstrate how the plan will maintain an adequate network over time.

The plan shall describe its provider services activities and identify key staff who will be assigned to the NHC.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.2.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The Department shall also evaluate the comprehensive of the plan's provider network, access for the NHC client, the plan's efforts in recruitment, and the plan's ability to maintain the provider directory information in an efficient and effective manner.

14.2.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall demonstrate an understanding of the medical, social and cultural needs of the NHC client population and the relationship of these needs to the size and characteristics of the provider network through the preparation and implementation of a workplan. The Department shall evaluate

the plan's ability to develop and maintain comprehensive network of providers, and the plan's willingness and interest in building a provider network unique to Medicaid.

14.3 Goal: To provide the NHC client "adequate" choice of more than one PCP.

14.3.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

Given the PCP's specialty type, the geographic location of the PCP in relation to the client's home and his/her mode of readily accessible transportation, location of specialty, hospital and ancillary services providers, and any other characteristics about the PCP that the client is considering when making his/her choice, the plan >s network shall be large and varied enough to meet the client's definition of " Adequate" .

The workplan shall include the use of geomapping and zip code information, at a minimum, to provide an analysis of the client's access to the provider network.

The workplan shall also include a description of how the plan intends to define " Adequate" and on what basis the plan intends to recruit providers, given the demographics of the NHC client population in the Designated Coverage Areas. Describe any proposed activities to obtain client input in plan's network development activities, e.g., focus groups.

The workplan shall indicate the plan's ability to collect and share demographical information about the providers pursuant to the Provider Network File by July, 1999. For example, such information as office hours, accessibility for the disabled, language capabilities, accessibility to bus routes, taxi services, and special limitations on patient populations, e.g., services for children only between the ages of 0 and ten years of age.

The workplan shall clearly indicate areas in the plan's network where the plan does not have adequate access, and identify a plan of correction.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.3.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The Department shall also evaluate the comprehensive of the plan's provider network, access for the NHC client, the plan's efforts in recruitment, and the plan's ability to maintain the provider directory information in an efficient and effective manner.

14.3.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall meet five requirements to demonstrate "adequacy" :

1) Provide client access to more than one PCP that is located within a twenty (20) mile radius or within forty-five (45) minutes of the client's home based on a readily accessible "mode" of transportation for the client;

2) Provide client access to more than one PCP that provides a medical home that is culturally diverse and sensitive, i.e., multi-lingual, same ethnicity, etc.;

3) Access to non-symptomatic office visits within forty-five (45) calendar days of request for appointment for adults;

4) Four (4) weeks for children less than four years of age; and

5) Access to non urgent, symptomatic office visit within forty-eight (48) hours of request for appointment.

The plan shall demonstrate compliance by describing its strategy for identifying and meeting the client's needs on an ongoing basis, and in its willingness and interest in exceeding the minimum requirement.

14.4 Goal: To affiliate with the teaching clinic(s), and if so, facilitate the requirement that the resident provide the "medical home" under the designated the supervising faculty member as the PCP.

14.4.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities

The workplan shall describe how the plan intends to educate the staff, providers and clients about the arrangement between the faculty member and the resident in

providing the client a " Medical home" , and in providing or arranging for appropriate referrals.

The teaching clinic environment may create additional challenges for the plan in coordinating care for the client in a consistent manner. The Department shall evaluate the plan's innovative educational and supportive programs to ensure a positive outcome for the client and the resident.

The plan should describe the faculty member to resident ratio, the number of clients that each faculty member will be responsible for through the extended care arrangement with the resident, and how it will provide assurances of a quality medical environment for the client.

The Department shall evaluate the plan's ability to provide ongoing education to the providers to ensure a high standard of service provision to the client. The Department will also evaluate the extensiveness of the provider's current experience in working with the Medicaid client, as well as the plan's current and future efforts to provide enhanced recruitment and education to ensure that the needs of the client are appropriately addressed by the providers in the plan's network.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.4.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

14.4.3 Minimum Requirement: At a minimum, the plan shall be considered in compliance if it effectively performs some type of activity in this performance area on a quarterly basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity that provides support and education to the client and participating physicians at the teaching clinics to ensure an effective " Medical home" on a quarterly basis.

14.5 Goal: Operationalizing the procedure to allow for a Designated Specialty Care Physician.

14.5.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify how the plan will incorporate the Department's Designated Specialty Care Physician procedures into business operations. The plan shall identify any training protocols, and staff responsible for coordinating the above issue with the Department.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

14.5.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

The Department shall evaluate the plan's ability to develop a protocol for this provision, and the plan's willingness to accommodate the client by allowing an "open referral" or providing consultative services for experience-sensitive conditions. The plan should describe any training protocols that it will develop for the client and the provider, and how it intends to monitor the effectiveness of the provision. The plan shall also be expected to report the number of occurrences and overall effectiveness of the provision.

14.5.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

14.6 Goal: Operationalizing the qualifications and responsibilities for physicians to participate as PCPs in the NHC.

14.6.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a description and documentation to establish that the plan is able to adequately meet the following PCP requirements:

(a) Utilization of Medicaid enrolled physicians, specialty, hospital and ancillary providers; and

(b) A provider and member handbook that communicates the NHC requirements to the physician. Describe how these requirements will be incorporated into the plan's credentialling program and contracting requirements. Specifically address the following requirements:

(1) Equitable treatment of the Medicaid client;

(2) The provision of the Basic Benefits Package per 471 NAC;

(3) The referral/authorization requirements for clients who require specialty care, hospital care, and other services when medically necessary per 471 NAC;

(4) Coordination when specialists, consultative services or other facilitated care situations are required for special needs clients;

(5) Requirement for physicians to provide 24 hour access, and how this will be communicated to the providers and monitored;

(6) Policy on discrimination;

(7) ADA and other similar requirements for the appropriate use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, etc., to accommodate the client's special needs;

(8) Procedure for requesting a transfer of the client to another PCP, and that the PCP shall continue to be responsible for the client as a patient until another PCP is chosen or assigned;

(9) Policy for disenrolling from participation in the NHC and timely notification to the plan so that an Interim PCP can be assigned;

(10) Maintenance and transfer of medical records pursuant to 471 NAC;

(11) Utilization of Enrollment Broker Services and Public Health Nursing;

(12) Communication with MH/SA providers of service and coordination of care issues;

(13) Communication with local public health agencies and requirements;

(14) Compliance with disease notification laws;

(15) Provision of information to the Department and other appropriate entities; and

(16) Communication with clients about treatment options.

The workplan shall describe how the plan will operationalize the Provider Network File and maintain the integrity of the file on an ongoing basis. Describe the plan's technical resources that will be dedicated to providing accurate and timely provider information via the Provider File Data Exchange. Describe the plan's willingness to designate one or more staff who have sufficient knowledge of the plan's systems and programmatic operations to serve as a contact for the Department for system's development, implementation, maintenance and problem-resolution. The workplan shall also address the its ability to maintain an accurate printed provider directory for the client.

The plan should describe its proposed protocols or workplans for ensuring the above requirements are incorporated into daily operations, how the responsibilities will be communicated to the physician, how the plan will ensure that the PCP is following the requirements, and the corrective action that will be taken if the PCP does not comply.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.6.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.6.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to educate the client and/or provider about the above NHC requirements that will facilitate provider performance, member education, and preventative health on a quarterly basis.

14.7 Goal: To provide and maintain an adequate number of PCP to ensure that the NHC client has the choice of more than one PCP.

14.7.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities. The workplan shall describe how the plan will communicate the PCP limit to the providers, coordinate this information among other NHC plans that a physician may be participating with, and how the plan will work with the physician to promote his/her providing the maximum number that s/he is comfortable providing in the NHC. Describe the plan's goals for maintaining/increasing the overall number of physician "Slots" available within the plan to ensure the NHC client receives an adequate choice of providers in the most accessible locations in the NHC coverage areas. Indicate by physician the number and type of physician extenders within the plan, and overall current and/or projected slot capacity per PCP.

Describe any restrictions that the plan may have restricting the number of managed care plans a physician may participate with and whether the plan would be willing to revise the restriction to allow a physician to participate in more than one plan within the NHC.

The workplan shall also include a description of how the plan intends to define "Adequate" and on what basis the plan intends to recruit providers, given the demographics of the NHC client population in the Designated Coverage Areas. Describe any proposed activities to obtain client input in plan's network development activities, e.g., focus groups.

The workplan shall indicate the plan's ability to collect and share slot information about the providers pursuant to the Provider Network File by July, 1999, and maintain this information on an ongoing basis.

The workplan shall clearly indicate areas in the plan's network where the plan does not have adequate access, and identify a plan of correction.

The initial workplan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.7.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues in the quarterly report. The Department shall evaluate the plan's understanding of the requirement and how well the plan has incorporated the requirement into its daily operations.

The Department shall also evaluate the comprehensive of the plan's provider network, access for the NHC client, the plan's efforts in recruitment, and the plan's ability to maintain the provider directory information in an efficient and effective manner.

14.7.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to promote participation in the NHC on a quarterly basis.

14.8 Goal: Operationalizing the procedure to allow for an Interim PCP.

14.8.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify how the plan will incorporate the Department's Interim PCP procedures into business operations. The plan shall identify any training protocols, and staff responsible for coordinating the above issue with the Department.

The workplan shall demonstrate how the plan shall inform staff and providers of the procedure. The plan shall include any proposed methods of educating the client about the requirement.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.8.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

The Department shall evaluate the plan's ability to develop a protocol for this provision, describe any training protocols that it will develop for the client and the provider, and how it intends to monitor the effectiveness of the provision. The plan shall also be expected to report the number of occurrences and overall effectiveness of the provision.

14.8.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

14.9 Goal: Operationalizing the requirements for providing the Basic Benefits Package and all related aspects of the NHC.

14.9.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a description and documentation to establish that the plan is able to adequately meet and operationalize the following requirements:

(a) The provision of the Basic Benefits Package for the NHC client pursuant to 471 NAC, including all treatment protocols, requirements for referrals and prior-authorizations, consultative referrals, " Open-ended" referrals, etc.;

(b) An " Adequate" number of PCP slots, access to the NHC client on an ongoing basis, allowances to growth in NHC enrollment over time, and the exchange of provider information to support the Provider Network Enrollment File;

(c) Providers that are Medicaid-enrolled;

(d) An appropriate range of services and access to preventive and primary care services in the designated coverage areas, and a sufficient number, mix, and geographic distribution of providers that are skilled in areas such a cultural diversity and sensitivity,

languages, accessibility to clients with mental, physical and communication disabilities, etc.;

(e) Subcontractual services, if appropriate;

(f) Compliance with PCP requirements;

(g) Acceptance of a client's choice without reservation or bias;

(h) Case management;

(i) Client handbook and other informational materials;

(j) Avoidance of any direct marketing, solicitation or indirect door-to-door, telephonic or other "cold-call" marketing;

(k) Quality Assurance/Quality Improvement activities and general principles of continuous quality improvement, and willingness to collaborate with the Department's QA/QI process;

(l) Compliance with the Americans with Disabilities Act (ADA) and appropriate accommodations for clients with special needs are met;

(m) Coordination with the Department, other NHC contractors, and other providers for services outside the Basic Benefits Package;

(n) Unrestricted access to "protected" services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;

(o) Clearly identified expectations for the PCPs, subcontractors and any other service providers participating in the client's managed care, and documentation of that care for quality assurance/quality improvement purposes;

(p) Retention of records and other documentation during the period of contracting;

(q) Use of State-designated laboratories and coordination with local and State public health agencies;

(r) Compliance with regulations providing for advance directives;

(s) Compliance with all state and federal regulations pursuant to this contract;

(t) Member services;

(u) Appropriate certificate of authority;

(v) Compliance with the Physician Incentive Program;

(w) An adequate panel of specialists, hospitals and ancillary providers to meet the needs of a client with chronic or severe medical conditions;

(x) Adequate notification and communication with the client and providers;

(y) Timely provider payments; and

(z) Refrain from billing the client.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff , providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.9.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.9.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to educate the client and/or provider about the above NHC requirements that will facilitate provider performance, member education and utilization management on a quarterly basis.

14.10 Goal: Operationalizing the requirements for complying with HEALTH CHECK (EPSDT).

14.10.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a description and documentation to establish that the plan is able to adequately meet the following requirements:

(a) The plan's HEALTH CHECK (EPSDT) program and how the plan will ensure that children receive HEALTH CHECK (EPSDT) services including follow-up treatment and subsequent medical, hearing, vision, and dental exams. Include a description of the plan's process for reminders, follow-up, and outreach to HEALTH CHECK (EPSDT) eligible clients and method to communicate HEALTH CHECK (EPSDT) requirements to providers. Describe the plan's process for HEALTH CHECK (EPSDT) outreach activities, immunizations and coordinated child-wellness and prevention care.;

(b) Goals for achieving compliance with the recommended participation rate;

(c) Compliance with the sixty (60) day requirements for a screening examination upon request by a client, and subsequent screening exams according to the appropriate periodicity schedules;

(d) The plan's immunization program, and protocols for participation in the Vaccine for Children program as well as coordination of related screening, treatment and reporting activities with State and Local Public Health Agencies;

(e) The plan's outreach program, and protocols for coordination with State and Local public health agencies on assessment, reporting and other educational services, e.g., screening for Elevated Blood Lead Levels, reporting to public health agencies and follow-up care for lead poisoned children will be accomplished;

(f) The plan's level of participation with maternal and child health programs and activities; and

(g) The plan's process for referrals to pediatric subspecialty providers, as well as the plan's capacity to provide such services.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff , providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.10.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.10.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

At a minimum, the plan shall complete or participate in at least one activity to educate the client and/or provider about the above NHC requirements that will facilitate provider performance, member education and utilization management on a quarterly basis.

14.11 Goal: Operationalizing the requirements for complying with cost avoidance and recoupment of Third Party Liability (TPL) pursuant to 13.43 of this contract.

14.11.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff , providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.11.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.11.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

14.12 Goal: Operationalizing the requirements for the provision of the Basic Benefits Package.

14.12.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify the plan's understanding of the each service, pursuant to 471 NAC. The workplan shall include a description of how the plan will operationalize the Department's interpretation of the service and how the plan shall communicate this to the providers in the plan's network and to the client.

The workplan shall include a description or matrix describing access, minimum allowances, referral and prior-authorization patterns for all services included in the Basic Benefits Package.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.12.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.12.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure and a willingness to work with the Department in the

interpretation of service delivery. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement

At a minimum, the plan shall complete or participate in at least one activity to educate the client and/or provider about the above NHC requirements that will facilitate provider performance, member education and utilization management on a quarterly basis.

14.13 Goal: Operationalizing the special provisions that apply to services requiring prior-authorization from the Department; unrestricted access; coordination for excluded services; transitional services involving mental health and substance abuse services; and access to FQHC.

14.13.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall identify the plan's understanding of the each service, pursuant to 471 NAC . The workplan shall include a description of how the plan will operationalize the Department's interpretation of the service and how the plan shall communicate this to the providers in the plan's network and to the client.

The workplan shall include a description or matrix describing access, minimum allowances, referral and prior-authorization patterns for all services included in the Basic Benefits Package.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.13.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.13.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan

on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure and a willingness to work with the Department in the interpretation of service delivery. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement

At a minimum, the plan shall complete or participate in at least one activity to educate the client and/or provider about the above NHC requirements that will facilitate provider performance, member education and utilization management on a quarterly basis.

14.14 Goal: Operationalizing a timely payment process.

14.14.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

14.14.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

14.14.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure and a willingness to work with the Department in the interpretation of service delivery. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement

At a minimum, the plan shall complete or participate in at least one activity to educate the provider about the above NHC requirements on a quarterly basis.

ARTICLE XV

15.0 PLAN RESPONSIBILITIES – QUALITY ASSURANCE/ IMPROVEMENT (QA/QI)

15.1 Introduction: The plan shall work collaboratively with the Department in effectively managing and monitoring the quality of care provided to clients, through a continuous QA/QI Program. In addition to developing and implementing the NHC program according to policy and procedures pursuant to this contract, the plan shall follow QA/QI methodologies, participate in all aspects of the QA/QI activities and comply with all performance and accountability measures.

15.2 Overall Quality Framework: The plan shall develop and implement, under the Department's oversight and monitoring, a continuous Quality Assurance/Quality Improvement (QA/QI) Program that meets the following guidelines:

(a) Is consistent with the Department's provision of Medicaid-covered services and utilization review requirements;

(b) Provides for review by appropriate health professionals of the process followed in delivering health services;

(c) Provides for the complete and timely collection of data sufficient for the accurate measurement of health plan performance and quality patient care;

(d) Provides for the regular and ongoing collection, analysis, interpretation and reporting of the plan's data; and

(e) Provides for making necessary changes through corrective action plans.

15.2.1 Access to Information: The plan shall make all its QA/QI records, including its findings and data, available to the Department. While the Department interprets all information provided by the plan is subject to the Nebraska Public records Act, the Department shall only provide information regarding the NHC in the aggregate.

15.2.2 Inspection Requirement: The Department, its contracted entities or designees, or HCFA officials, may evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the NHC. The plan shall maintain an appropriate record system for services to NHC clients.

15.3 Continuous Quality Assurance/Quality Improvement (QA/QI) Program: The plan shall establish an internal, continuous QA/QI program that provides a mechanism for the plan to monitor, evaluate and take action to improve the quality of care.

15.3.1 QA/QI Standards: The plan is required to develop and implement QA/QI activities based on standards defined in the Department's Quality Assurance Plan (QAP) and pursuant to 1932(c)(1) of the Social Security Act. The Department's

QAP is based on the QA guidelines developed by the Health Care Finance Administration (HCFA) as part of its Quality Assurance Reform Initiative (QARI), Health Care Quality Improvement System (HCQIS) and Quality Improvement System for Managed Care (QISMC).

15.3.2 Quality Assurance Defined: The National Association for Healthcare Quality defines QA as a process where performance is measured against expectations and a corrective action is taken. Quality improvement is defined as a means of raising quality performance to unprecedented levels. The overall success of the NHC is measured by physician participation, client awareness, focus on prevention and outcome measurements. Quality means meeting or exceeding the client's expectations of services. The NHC strives to provider greater access to services, improve the quality of clinical outcomes and assure appropriate utilization of services.

15.3.3 Cooperative Effort: The Department and the plan shall work cooperatively to develop and implement an effective QA/QI Program pursuant to this contract.

15.4 Purpose: The purpose of the NHC's QA/QI program shall be to continuously improve the quality of care and services provided to all clients enrolled in the NHC and to identify and act upon opportunities for improvement. The plan shall promote the delivery of health care and services in accordance with established benchmarks and performance goals and measure performance against the benchmarks in order to improve performance.

15.5 Goals: The plan shall comply with the following goals for the NHC's QA/QI program:

(a) Provide a mechanism by which the quality of clinical care can be assessed, monitored, evaluated and improved;

(b) Provide a mechanism by which the quality of services can be regularly assessed, monitored, evaluated and improved;

(c) Define the authority of the Quality Assurance Committee (QAC) committee and subcommittee(s) and their responsibility to the governing body;

(d) Encourage provider and client participation, therefore ensuring that stakeholders are involved in the process; and

(e) Promote awareness to issues pertinent to the community's health and well-being.

15.6 Objectives: The plan shall comply with the following objectives for the NHC's QA/QI program:

(a) Define the population that is served and identify quality initiatives specific to the population;

(b) Utilize information and data on, at a minimum, a quarterly basis to measure the quality of care and services being provided;

(c) Establish a provider network that is knowledgeable of the concepts of continuous QA/QI and that is able to incorporate them into all aspects of the NHC;

(d) Encourage clients to give feedback and provide an accessible mechanism to voice concerns;

(e) Promote provider feedback and provide an accessible mechanism for them to voice concerns;

(f) Develop relationships with public health and community programs; and

(g) Evaluate the effectiveness of the QA/QI program and continue to strive for improvement.

15.7 Scope: The plan shall be involved in all aspects of the NHC to ensure a comprehensive QA/QI Program.

15.7.1 Non-Clinical Care: The QAP shall address the quality of non-clinical aspects of services, e.g., Client Participation and Enrollment Processes, Interface with the Enrollment Broker Services, System Requirements, Implementation Activities and Timelines, and Contract Summary.

15.7.2 Functional Areas: In accordance with the standards established by the National Committee on Quality of Care (NCQA), the QAP shall also address the following functional and/or clinical areas:

(a) Quality Improvement;

(b) Utilization Management;

(c) Credentialling;

(d) Member Rights and Responsibilities;

(e) Preventive Health Services; and

(f) Medical Records.

15.7.3 QA/QI Review and Evaluation: The QAP allows for an objective and systematic review and evaluation of the quality and appropriateness of all care and services delivered for the NHC.

15.7.4 Basis for Review: Collection of information and data based on demographic groups, care settings (e.g., inpatient, ambulatory, home care, physician offices) and the type of services provided (e.g., primary care, specialty care, ancillary care, preventative care) is critical to the success of the NHC. Through the use of peer review, trending and data analysis, patterns emerge that can be compared to established standards.

15.7.5 Review Results: The results of the review and evaluation shall be used to take corrective action, establish new benchmarks, demonstrate effectiveness, and/or identify needs.

15.7.6 QA/QI Staff: The QAP developed by the plan shall identify staff who are responsible for the operation and success of the QA/QI program. Such person(s) shall have adequate and appropriate experience and shall be accountable for all QA/QI activities of the plan, along with participating in the Department's collaborative QA/QI process.

15.8 Quality Assurance Committee: The Department's QAC provides the administrative oversight necessary to perform the QA/QI activities of the QAP.

15.8.1 QAC Defined: The committee is an inter-disciplinary committee that includes providers, administrative staff, and other stakeholders as deemed appropriate by the Department. The Department shall establish a QAC to meet these requirements.

15.8.2 QAC of the Plan: Each plan shall incorporate the same administrative infrastructure into their program, to include a QAC, Board of Directors, Medical Director and QA/QI Management Staff.

15.8.3 QAC Responsibilities: The QAC, within the Department, shall have the responsibility to:

(a) Identify priorities specific to the health, well-being and services provided to the NHC clients;

(b) Determine indicators by which the quality of care and service can be monitored;

(c) Review data and information designed to monitor and evaluate the quality and appropriateness of the care and services provided on, at a minimum, a quarterly basis;

(d) Recommend actions to improve the quality of care and services;

(e) Annually review the effectiveness of the QAP, and make commendations for changes, if appropriate; and

(f) Submit quarterly reports, at a minimum, to the Department and the plan that summarize the QA/QI activities of the NHC, including any recommendations.

15.9 Quality Assurance Subcommittees: The Department shall focus on the following activities, in the form of subcommittees (consisting of providers, administrative staff and other persons deemed appropriate by the committee/Department), and reporting and related activities, to evaluate the effectiveness of the NHC. The Department will utilize the most recent HEDIS criteria, and other continuous QI specifications, to measure compliance in all of the following areas:

15.9.1 Utilization Management: The Department shall provide oversight and monitor the plan in the following areas:

(a) Development of practice guidelines;

(b) Application of " Medical necessity criteria" in making medical determinations;

(c) Procedures, diagnoses and services selected for monitoring;

(d) Data and information obtained from the results of studies and trending and any resulting recommendations for change;

(e) Reports completed by the committee;

(f) Annual review and any updates to the plan's Utilization Management Plan; and

(g) The following focus areas, at a minimum:

(1) Average Length Of Stay;

(2) Admissions per 1000 Clients;

(3) Days per 1000 Admissions;

(4) Emergency Room Usage;

(5) C-Section Rates;

(6) PCP visits per 1,000 Clients;

(7) Specialty Visits per 1,000 Clients;

(8) Prenatal Care in the First Trimester; and

(9) Denials.

15.9.2 Credentialling: The Department shall provide oversight and monitor the plan in the following areas:

(a) Criteria used in performing credentialling and re-credentialling;

(b) Ability to systematically access the qualifications of potential providers using the approved criteria;

(c) Approval process for providers to meet the credentialling standards;

(d) Recommendations/procedures when the provider fails to meet the standard;

(e) Information-sharing activities (in collaboration with Credentialling) that educate the providers about the role of the PCP, QA and UM criteria, trends in medical management, outcomes and benchmarks, etc.;

(f) Procedures for re-credentialling providers every two years, and recommendations for corrective action; and

(g) Annual review and updates to the Credentialling Plan.

(h) The following business practices, monitoring and corrective action activities, at a minimum:

(1) Number of PCPs credentialled and recredentialled;

(2) Number of Specialists credentialled and recredentialled;

(3) Number of Ancillary Providers approved; and

(4) Length of time from contracting to credentialling.

15.9.3 Network Development: The Department shall provide oversight and monitor the plan in the following areas:

(a) Identification of adequate provider networks to meet the medical needs of the clients;

(b) Education and promotional activities to create incentives for the provider to participate in the NHC;

(c) Activities to promote increased participation in number of physicians, specialty groups and willingness to accept increased numbers of clients;

(d) Activities to ensure adequate access to providers at levels of care for all clients enrolled in managed care; and

(e) Annual review and updates to the Provider Network Development Plan.

(f) The following business practices, monitoring and corrective action activities, at a minimum:

(1) PCP proximity that provides clients access to one or more affiliated PCPs within a twenty-mile radius or 45 minutes from their home;

(2) Access for non-English speaking clients to one or more multi-lingual PCPs that have the capability of providing services to, and speaking to the clients in his/her own language;

(3) Access (i.e., face-to-face, telephone and written) for persons with disabilities that ensures that physical and communication limitations do not inhibit persons with disabilities from obtaining services;

(4) Availability of open physician practices that ensures no more than 10% of the plan's physician practices are closed or frozen to new clients on a monthly average; and

(5) Adequate availability to the Medicaid client, e.g., office hours on Saturday, locations on a bus route, etc.; and

(6) Number of PCPs and specialty providers in the plan network, the number of PCPs with physician extenders and the number of PCPs who have agreed to accept the maximum number of clients to physician ratio, i.e., slots.

15.9.4 Provider Performance: The Department shall provide oversight and monitor the plan in the following areas:

(a) Monitoring activities that encourage a physician to provide efficient and effective non-urgent and urgent services;

(b) Educational activities that ensure providers in the plan's network have current and adequate information about providing services in the Basic Benefits Package;

(c) Educational activities that ensure providers in the plan's network have efficient and effective referral and prior-authorization procedures for providing quality of care to clients; and

(d) Annual review and updates to the Provider Performance Plan.

(e) The following business practices, monitoring and corrective action activities, at a minimum:

(1) Access to non-symptomatic office visits within forty-five (45) calendar days of request for appointment for adults and four (4) weeks for children less than four years of age;

(2) Access to non urgent, symptomatic office visit within forty-eight (48) hours of request for appointment;

(3) Access to emergency care services, as well as educational and alternatives services, to control the utilization of emergency medical services; and

(4) Training protocols to educate providers about the NHC and the Basic Benefits Package.

15.9.5 Member Advocacy and Education: The Department shall provide oversight and monitor the plan in the following areas:

(a) Identification of the educational needs of the clients enrolled in managed care;

(b) Twenty-four hour member services line, medical triage services and general problem-solving services;

(c) Information-sharing activities that educate the client about prevention, safety, education and disease management; and

(d) Development of relationships with, and participation in, community groups, activities, etc.

(e) The following business practices, monitoring and corrective action activities, at a minimum:

(1) PCP-requested transfers;

(2) Complaints/grievances;

(3) Client satisfaction;

(4) Case management;

(5) Member services;

(6) Member education;

(7) Cultural competency; and

(8) Provision of interpreters and other required accommodations.

15.9.6 Preventative Health: The Department shall provide oversight and monitor the plan in the following areas:

(a) Identification of preventative health issues pertinent to the clients enrolled in the NHC;

(b) Development of the Preventative Health Guidelines (annually and any updates);

(c) Educational tools or resources utilized to improve preventative health outcomes;

(d) Activities aimed at increasing public awareness about the use of prevention to improve the quality of health;

(e) Development and Use of Consensus Guidelines;

(g) Participation and cooperation with Federal, State and Local Public Health agencies, programs and other initiatives.

(h) The following business practices, monitoring and corrective action activities, at a minimum:

(1) Health Services for School Age Children/ Immunization rates;

(2) Mammography rates;

(3) Cervical Screening rates;

(4) Pediatric Asthma (e.g., Asthma emergency room visits and hospitalization rates);

(5) Diabetes (e.g., hospital admissions with ketoacidosis rates) utilizing supportive information from the Nebraska Diabetes Consensus Guidelines pursuant to this contract;

(6) Prenatal Care;

(7) HEALTH CHECK (EPSDT);

(8) Disabilities;

(9) STD, specifically Chlamydia;

(10) HIV/AIDS;

(11) Elevated Blood Lead Levels; and

(12) Tuberculosis.

15.9.7 Medical Records: The Department shall provide oversight and monitor the plan in the following areas:

(a) Criteria for medical record and facility reviews;

(b) Ability to systematically access the qualification of potential providers using the approved criteria;

(c) Process to approve providers who meet the medical records standards;

(d) Process to monitor and make recommendations for providers who fail to meet the medical records standards;

(e) Information-sharing activities (in collaboration with Credentialling, Utilization Management and the QAC) to educate the providers about the role of the PCP, review criteria used to perform credentialling, medical record and facility assessments, quality assurance and utilization management, trends in medical management, outcomes, and benchmarks used to evaluate the potential providers; and

(f) Medical record and facility assessment criteria (annual reviews and updates).

(g) The following business practices, monitoring and corrective action activities. at a minimum:

(1) Number of medical records and facility assessments performed;

(2) Number of medical records and facility assessments approved; and

(3) Completeness of the patient's medical record, to include but not limited to:

a. Identification of the client;

b. The name of the client physician;

c. The plan of care to include but not limited to diagnoses, symptoms, complaints, and complications, a description of the individual's functional level, any orders for medication, treatments, restorative and rehabilitative services, activities, social services, diet;

d. The initial and subsequent continued stay review dates if admitted to a hospital;

e. Date of operating room reservations, if applicable;

f. Justification of emergency admissions, if applicable;

g. Reasons and plan for continuous stay if hospitalized; and

h. Completed medical history, to include childhood immunizations and other communicable/reportable conditions and treatments.

15.10 Provider Participation: The plan shall inform participating providers about the NHC's QA/QI Program through, but not limited to, the following activities:

(a) Initial contracting process with the plans;

(b) Provider handbooks, newsletters and other information-sharing activities produced by the plans;

(c) Provider meetings conducted by the Department and the plan;

(d) Provider focus groups conducted by the Department; and

(e) Provider newsletters and notifications Issued by the Department.

15.10.1 Provider Involvement: Providers are encouraged to participate in the NHC by becoming PCPs or network providers in the NHC and/or becoming members of the various focus groups, subcommittees or QAC.

15.10.2 Access to Medical Records: Participating providers shall allow the plan and Department access to medical records and facilities for purposes of performing QA/QI activities.

15.11 Data and Information Sources: The Department shall utilize the following sources to identify opportunities for improvement:

(a) Medical records;

(b) Member complaints/grievances;

(c) Satisfaction surveys;

(d) Utilization management data;

(e) Claims processing activities;

(f) External audit reports;

(g) Client service reports;

(h) Encounter data; and

(i) Enrollment.

15.11.1 Documentation of Usage of Medicaid Funds: The plan shall have methods to verify whether services reimbursed by Medicaid were actually furnished to clients by providers of the plan and subcontractors.

15.12 Review Process: A potential quality of care concern shall be forwarded to the Department's QA/QI Manager, and to the plan's QA/QI Department. Additional information will be gathered by the Department and/or the plan, as appropriate. The concern shall be shared with the Department's and/or the plan's QAC. If necessary, a physician of like specialty shall be asked to review the case and submit any comments or recommendations in writing. The QACs of the Department and plan shall review the concern and make any final recommendations.

15.13 Levels of Concern: Quality of care or service concerns identified through the QA /QI process will be categorized for assessment, intervention and resolution as follows:

(a) Serious: The problem resulted in, or contributed to, the death of a patient or seriously jeopardized the health of a patient (though the eventual outcome may have been satisfactory). Immediate intervention by the Medical Director of the plan and the Department is required at the provider and the entity level.

(b) Substantial: The problem involved a significant deviation from the Community/National standards of care with respect to diagnosis, treatment, or expected outcome; direct intervention by the Medical Director of the plan and the Department at the provider and entity level is required.

(c) Minor: The problem had a minimal or inconsequential effect on the health status of the member; intervention not required, continue to monitor to identify trends; direct intervention at the provider level not required.

(d) Service: The problem involves the healthcare delivery system and did not directly impact the medical intervention not required for health of the client but did impact the client's satisfaction. Ongoing monitoring to identify trends required.

15.14 Corrective Action: When the QAC of the Department determines the inappropriate care or substandard services have been provided, or services which should have been furnished have not been provided, the QAC shall be responsible for communicating concerns identified and outlining the corrective action necessary.

15.14.1 Role of the Medical Director: The Medical Director of the Department shall be responsible for working with the plan/provider to develop and implement a corrective action plan, if appropriate.

15.14.2 Final Actions by the QAC: The QAC is responsible for communicating a summary of the case, findings and corrective action recommended to the Department's contract manager for any additional action. The QAC can recommend/initiate the following actions:

(a) Letter of information;

(b) Letter of censure, requested plan/provider response;

(c) Site visit, with correction action plan required;

(d) 100% review of all cases;

(e) Second opinion for all surgical cases;

(f) Plan/provider be closed to new members;

(g) Suspension; and

(h) Termination.

15.15 Quality Improvement Process: As a means of measuring quality, and in conjunction with Preventative Health, the Department shall conduct focused studies, and require the plan to pursue continuous quality improvement in the following areas:

(a) Health Services for School Age Children/ Immunization;

(b) Mammography;

(c) Cervical Screenings;

(d) Pediatric Asthma;

(e) Diabetes;

(f) Prenatal Care;

(g) HEALTH CHECK (EPSDT);

(h) Disabilities;

(i) STD, specifically Chlamydia;

(j) HIV/AIDS;

(k) Elevated Blood Lead Levels;

(l) Tuberculosis; and

(m) Additional items as contained in the most recent HEDIS criteria as determined by the Department.

15.15.1 Subcommittees: The Department utilizes participation from the Department, the plan, providers, clients, and other entities with expertise in the above areas to form subcommittees of the Department's QAC to develop standards for evaluating quality improvement and quality of care in the NHC.

15.16 Plan Review: The Department is responsible for monitoring the QA/QI activities of the plan, and facilitating any necessary corrective action that should be taken by the plan. The Department shall monitor the plan's adherence to internal QAP standards through the following mechanisms:

(a) External Quality Review: The Department is required to monitor the quality of care provided by the plan/provider through an annual, independent, external review. The Department Contracts with the Iowa Foundation of Medical Care, which is the Peer Review Organization (PRO); and

(b) Periodic Medical Audits: The Department is required to conduct periodic medical audits to ensure that each plan furnishes quality and accessible health care to enrolled clients. These audits are conducted at least annually and must identify and collect management data.

15.16.1 Purpose of the Plan Review: Through these methods, the Department shall work with the plan to achieve compliance with the Department's QAP standards and develop a corrective action plan for any identified deficiencies in delivering services. The Department shall monitor the plan to ensure that the corrective plans are implemented and effective. The plan is required to cooperate with the federally mandated and the Department's designated External Quality Review Organization (EQRO).

15.17 Review Activities: Through the use of external and internal review activities, the Department shall focus on the following areas:

(a) Medical Record Review, to include but not limited to:

(1) Organization of Medical Record;

(2) Patient Information;

(3) Content of Medical Records;

(4) Continuity of Care; and

(5) Health Promotion.

(b) Quality Management and Improvement, to include but not limited to:

(1) Program Structure;

(2) Program Operation;

(3) Health Services Contracting;

(4) Continuous Quality Improvement;

(5) Member Satisfaction;

(6) Health Management Systems;

(7) Clinical Practice Guidelines;

(8) Quality Management/Quality Improvement Studies/Assessments;

(9) Effectiveness of the Quality Improvement Program; and

(10) Delegation of Quality Improvement Activity.

(c) Utilization Management, to include but not limited to:

(1) Policies and Procedures;

(2) Utilization Management Procedures; and

(3) Utilization Management Documentation.

(d) Credentialling and Recredentialling, to include but not limited to:

(1) Policies and Procedures;

(2) Credentialling Documents; and

(3) Recredentialling Documents.

(e) Member Rights and Responsibilities, to include but not limited to:

(1) Policies and Procedures;

(2) Member Responsibilities;

(3) Plan Responsibilities; and

(4) Confidentiality.

(f) Disease Prevention and Health Promotion Services, to include but not limited to:

(1) Disease Prevention and Health Promotion Services;

(2) Participation with Public Health Agency initiatives, disease reporting requirements, and preventative health programs.

15.18 Accreditation: The plan shall meet all NCQA (National Committee for Quality Assurance) requirements for accreditation, and to meet any subsequently federally mandated national standards, as a managed care organization. If the plan does not have current NCQA accreditation, the plan shall pay for submit to a NCQA readiness evaluation prior to the July, 1999 and completion of the contract negotiation process. The NCQA areas that will be monitored by the Department are:

(a) Administrative Policies and Procedures;

(b) Advertising and Marketing for Managed Care Organizations;

(c) Utilization Management;

(d) Credentialling and Recredentialling;

(e) Members' Rights and Responsibilities;

(f) Preventive Health Services; and

(g) Medical Records.

15.18.1 Contract Deliverables: The Department shall utilize contract deliverables to document the plan's compliance with NCQA standards.

15.19 Encounter Data: The plan shall submit encounter data, per Departmental specifications, and to participate in all encounter data review and technical-readiness assessments.

15.19.1 Submission of Encounter Data: The plans shall submit all data reflecting all services provided to the NHC clients contracted or delegated. The plans shall have processes in place to ensure that all data submitted to the Department reflects all services rendered within the last ninety (90) days.

Encounter data submissions shall:

(a) Be submitted on a monthly basis;

(b) Include all services;

(c) Involve administrative fees for non-submission or late submission; and

(d) Be used to evaluate plan performance and whether the plan is offered an option to contract beyond the first two years of the contract period.

15.19.2 Penalties: The Department shall impose contractual penalties for the non-submission, incomplete or late submission of encounter data.

15.19.3 Re-Submission of Data: Any data rejected as part of the encounter data submission shall be resubmitted.

15.20 Other Measures: The most recent HEDIS criteria and other continuous QI specifications are the tools for quality measurement that shall be utilized by the Department. The following HEDIS and HEDIS-like measures will be reported by the plans through the submission of encounter data. Data analysis, trending and comparative studies with national and program-specific standards will allow the Department to establish benchmarks and QA/QI activities for the NHC. The Department shall utilize

(a) Encounter data;

(b) Programmatic and contract deliverables; and

(c) Results from the various oversight/monitoring activities pursuant to this contract to evaluate the following NHC underlying principles:

1. Improved health, wellness and quality of care;

2. Cost-effective quality health services;

3. Increased access to primary care;

4. Expanded choices;

5. Greater coordination and continuity of care; and

6. Better health outcomes through effective care management.

15.21 Reporting: Through the use of encounter data, the Department shall develop measures to focus on the following quality issues:

(a) Expenditures/Usage

(b) Eligibility

(c) Utilization

(d) Quality;

(e) Provider Access

(f) Provider Expenditures

15.21.1 Performance Measures: In addition to developing and implementing the NHC program according to policy and procedures, the plan shall follow QA/QI methodologies, adhere to all specified reporting requirements , and comply with all elements pursuant to this contract.

ARTICLE XVI

16.0 GOALS/MEASURES - QUALITY ASSURANCE and QUALITY IMPROVEMENT

16.1 Goal: To develop and maintain a comprehensive QA/QI program.

16.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The workplan shall address the following areas:

(a) The internal, continuous QA/QI program that provides the plan a mechanism to monitor, evaluate and take action to improve the quality of care, based on standards defined in the Department's Quality Assurance Plan (QAP);

(b) The purpose and how the plan's QA/QI Program shall promote the delivery of health care and services in accordance with established benchmarks and performance goals, and how performance is measured against the benchmarks in order to improve performance;

(c) The goals of the plan's QA/QI Program;

(d) The objectives of the plan's QA/QI Program;

(e) The scope of the plan's QA/QI Program that addresses the six NCQA functional areas, and that through the use of peer review, trending and data analysis, patterns that emerge will be used to establish standards that will be used to take corrective action, establish new benchmarks, demonstrate effectiveness and/or identify needs;

(f) The responsibilities of the plan's QAC;

(g) The areas of evaluation through subcommittee activities, and reporting;

(h) Avenues for keeping providers informed of the plan's QA/QI Program;

(i) Data and informational sources that shall be utilized to identify opportunities for improvement;

(j) The process for reviewing a quality of care issue;

(k) The levels of concern and the resulting action taken, when appropriate by the Department;

(l) The plan's corrective action procedures;

(m) The plan's Preventative Health Focused Study Areas;

(n) The method for plan review and subsequent corrective action plans; and

(o) Compliance with all NCQA requirements for accreditation and any subsequently approved national standards.

The plan shall address its own QA/QI Program in relation to the components of the Department's NHC QA/QI Program.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

16.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

16.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

The Department shall evaluate the plan's willingness to cooperate with the Department, other contracted plans and the EBS in the overall development and implementation of the QA/QI Program for the NHC. The Department shall evaluate the plan's understanding, philosophy and commitment to the QA/QI concepts, and its willingness to collaborate with the Department in the QA/QI goals, and the reporting necessary to evaluate the overall program.

16.2 Goal: To submit encounter data as a means of evaluating the quality of care provided by the NHC and other similar reporting requirements.

16.2.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The plan shall address its own QA/QI Program in relation to the components of the Department's NHC QA/QI Program.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

16.2.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

16.2.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

The Department shall evaluate the plan's willingness to cooperate with the Department, other contracted plans and the EBS in the overall development and implementation of the QA/QI Program for the NHC. The Department shall evaluate the plan's understanding, philosophy and commitment to the QA/QI concepts, and its willingness to collaborate with the Department in the QA/QI goals, and the reporting necessary to evaluate the overall program.

ARTICLE XVII

17.0 PLAN RESPONSIBILITIES - RIGHTS AND RESPONSIBILITIES

17.1 Introduction: The plan shall ensure that the client is fully informed, in writing and verbally, of his/her rights and responsibilities as well as avenues for pursuing complaints and grievances. Similarly, providers participating in the managed care networks are entitled to the same processes as any Medicaid-enrolled provider according to 471 NAC. "System Advocacy, Cultural Diversity and Sensitivity" , defines a process as well as a philosophy designed to ensure that anyone utilizing the programs and services within the Health and Human Services System is able to do so in an efficient and effective manner. It is the intent of the HHS System to incorporate these principles into the managed care program.

17.2 Rights and Responsibilities for Clients Enrolled in the Basic Benefits Package: The following rights and responsibilities apply to clients participating in the NHC. Each plan shall inform the client, in writing and orally, about his/her rights and responsibilities.

17.2.1 Client Rights: The client has the right to:

(a) Be treated with respect and without discrimination;

(b) Be given information about his/her illness or medical condition; understand the treatment options, risks and benefits; and make an informed decision about whether s/he shall receive a treatment;

(c) Talk with the PCP and know his/her medical information will be kept confidential;

(d) Choose his/her PCP and plan;

(e) Receive medical care in a timely manner;

(f) Make a complaint about the PCP or plan, and receive a timely response;

(g) Receive information about services included in the Basic Benefits Package;

(h) Request a fair hearing according to 465 NAC;

(i) Receive proper medical care 24 hours a day, seven days a week;

(j) Change his/her PCP or plan;

(k) Formulate advance directives, if desired;

(l) Have materials explained or interpreted;

(m) Have interpreters, if necessary, during medical appointments and in all discussions with the PCP/plan; and

(n) Have access to the PCP/plan.

17.2.2 Client Responsibilities: The client has the responsibility to:

(a) Understand, to the best of his/her ability, how the NHC impacts his/her health care and how to use health care services, and locate available resources to obtain answers to questions;

(b) Choose a PCP/plan;

(c) Keep his/her scheduled appointments;

(d) Inform providers in advance if appointments must be canceled;

(e) Fully inform the PCP of his/her medical providers;

(f) Ask questions about things s/he does not understand;

(g) Decide whether to receive a medical treatment or procedure;

(h) Follow his/her PCP's recommendations;

(i) Facilitate transfer of his/her medical records;

(j) Obtain all covered services through the PCP, either directly or by referral from the PCP/plan;

(k) Take the NHC Identification (ID) Document to all medical appointments;

(l) Whenever possible, work with the PCP/plan for the provision of emergency services in the most appropriate setting;

(m) Accept financial responsibility for any services according to 482 NAC;

(n) Inform HHS staff and the EBS if his/her address has changed, she is pregnant, s/he otherwise has a change that could affect his/her Medicaid eligibility or NHC coverage; and

(o) Cooperate with all NHC inquiries and surveys.

17.2.3 Discrimination: The plan shall ensure that no person is subjected to discrimination in any HHS program or activity based on his/her race, color, sex, age, national origin, religious creed, political beliefs or handicap.

17.2.4 Adequate Notice: The Department shall send adequate notice sent notifying the client of any action(s) affecting his/her NHC enrollment. The notice shall include a statement describing the action(s) is, the reason(s) for the intended action and the specific manual reference supporting the action(s) or the federal or

state law that requires the action(s). The plan shall notify the client of any action(s) regarding the provision of a service.

17.3 Provider Rights and Responsibilities: The plan shall ensure that the providers participating in the NHC have the same rights and responsibilities as any Medicaid-enrolled provider pursuant to this contract:

17.4 Grievance/Appeal Process: The plan shall inform the client, in writing and verbally, of the grievance/appeal process for challenging the denial or payment of medical services.

17.4.1 Avenues for Resolving a Client Grievance/Appeal: The client, his/her legal representative, or the EBS and/or provider on behalf of the client, has the following avenues for resolving a complaint or grievance:

(a) Contact the EBS verbally or in writing. The EBS shall respond to the client or provider within five working days and shall assist the client in:

(1) Identifying the issue;

(2) Determining whether the issue can be resolved informally or whether a formal grievance is warranted;

(3) Formulating the best course of action;

(4) Following through with the agreed upon plan of action; and

(5) Processing a more formal grievance;

(b) Contact the plan, according to the plans' internal grievance procedure, pursuant to 1931(b)(4) of the Social Security Act;

(c) Contact the State Ombudsman, who shall ensure the client has received appropriate assistance and all procedures and policies have been followed; and

(d) File a formal appeal request following procedures outlined in Title 465 NAC. For purposes of NHC, the ninety days to file a formal appeal begins from the date of agency action. Filing an appeal request does not preclude resolution of a complaint or grievance through other avenues.

17.4.2 Sequence: Attempts should be made to resolve the complaint or grievance at the most informal level possible. However, the client is not required to take advantage of each avenue in the sequence stated above.

17.4.3 Access to Fair Hearing: Clients may access the fair hearing process at any time. The plan, EBS and Department shall maintain responsibility for notifying the client about the fair hearing rights in a manner that ensures adequate notice.

17.4.4 Continuation of Services: The Department and plan shall continue services during an appeal, or reinstate services if the Department or plan take action without the advance notice, consistent with the following fair hearing procedures.

(a) The Department and plan shall continue services during an appeal if the Department mails the notice as required and the client request a hearing before the date of action; and

(b) The Department and plan shall reinstate services if the Department takes action without the advance action required; the client's whereabouts are unknown but during the time the client is eligible for services the client's whereabouts become known, or the client requests a hearing within ten days of the mailing of the notice of action; and the Department determines that the action results from other than the application of State or Federal law or policy.

17.4.5 Documentation: All contacts with the EBS and plan regarding complaints or grievances shall be documented and submitted to the Department.

17.4.6 Fair Hearings: The client has a right to appeal under 465 NAC. Hearings are scheduled and conducted according to the procedures outlines in 465 NAC pursuant to Addendum E (Pertinent Regulations).

17.4.7 Avenues for Resolving Provider Grievances/Complaints: A provider has the right to appeal under 471 NAC and pursuant to this contract. Hearings are scheduled and conducted according to the procedures outlined in 465 NAC.

17.5 System Advocacy: The plan shall support the principles of "System Advocacy" . System advocacy provides a unified, accessible, accountable, caring and competent health and human services system for each client that maximizes local determination to achieve measurable outcomes.

17.5.1 Responsibilities: The plan shall comply with the following System Advocacy responsibilities:

(a) Assessing the client's questions, concerns and complaints and directing them to the appropriate system areas or agency for a response;

(b) Helping the program understand the issues of the client, if necessary;

(c) Assisting the client in finding an answer at the closest possible level; and

(d) Ensuring the client gets an appropriate response.

17.5.2 Philosophy: The plan shall comply with the following administrative philosophy:

(a) All people have a right to be treated with dignity;

(b) Responsiveness and follow-through is to be given a high priority;

(c) Procedures shall not duplicate the work of existing agencies or appeal processes;

(d) All information is to be treated confidentially;

(e) Resources will be appropriately allocated;

(f) Change and innovation are encouraged to address changes in the environment; and

(g) Maintain ongoing and responsive internal and external communication.

17.6 Cultural Sensitivity and Diversity: HHS is a culturally diverse environment that exercises zero tolerance of any acts of discrimination, racism, or prejudice. Understanding, valuing and promoting cultural sensitivity and diversity shall be a part of the ongoing philosophy of the Department of Health and Human Services and any of its programs. The plan shall promote this philosophy with the client, providers and within in the workplace.

ARTICLE XVIII

18.0 GOALS/MEASURES - RIGHTS AND RESPONSIBILITIES

18.1 Goal: To develop and maintain a program that promotes the rights and responsibilities for the client and provider, and that educates the client and provider about avenues to file a grievance, complaint or appeal.

18.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

18.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

18.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

ARTICLE XVIX

19.0 PLAN RESPONSIBILITIES - SYSTEM REQUIREMENTS

19.1 Introduction: System requirements have been addressed throughout this contract. The plan shall have sufficient resources and technology to support the necessary exchanges of information. All system requirements and informational exchanges between the Department and the plan shall be operational by July, 1999. The plan shall comply with the following systems required requirements:

Requirement	Frequency	State/Plan Initiated	Receipt Required By State/Plan
Enrollment-Related			
• Initial Enrollment Letters 0 Days ' Attempt 1 8 Days ' Attempt 2 16 Days ' Attempt 3 24 Days ' Attempt 4 32 Days ' Attempt 5 40 Days ' Attempt 6 >45 Days ' Auto Assignment	Daily	State	N/A
• 60-Day Reenrollment Notice	Daily	State	N/A
• Outreach Attempt/Overflow Reports (Documentation)	Daily	State	N/A
• Health Assessment	Monthly	State	Plan
• Client Notices	Monthly	State	N/A
• NMES Update	Daily	State	N/A
• Identification Document	Monthly	State	N/A
• Enrollment File Layout	Monthly	State	Yes
• Interim PCP Transfers	Daily, as necessary	Plan	State
• Medicaid Provider File	Weekly	State	Plan
• Provider Network Enrollment	Request	Plan	State

Requirement	Frequency	State/Plan Initiated	Receipt Required By State/Plan
Claims-Related			
• Encounter Data (HMO only)	Daily	Plan	State
• CAP/PCP Fee Payment	Monthly	State	Plan

Requirement	Frequency	State/Plan Initiated	Receipt Required By State/Plan
Data Management/Reporting			
• Medicaid Recipient File to The Medstat Group	Monthly	State	N/A
• Medicaid Provider File to The Medstat Group	Monthly	State	N/A
• Medicaid Claims File to The Medstat Group	Monthly	State	N/A

The Department Contracts for services from Central Data Processing, which is responsible for all systems support for the State. The State can electronically send or receive data files from the State's mainframe to other mainframes, UNIX, AS400 or PCs. The State utilizes a product called Connect Direct. In order for the plan to send or receive information electronically from/to the State, the plan must have either of the following:

1. A License of Connect Direct; or

2 A Leased Line to the State's VTAM or be an IBM Advantis Client (allowing access to the State.

19.2 Claims Editing: The Department Claims Processing is programmed to deny any claims submitted by a provider for a client who is enrolled with a plan in the NHC. These claims will be returned to the provider with instructions to submit the claim to the appropriate plan.

ARTICLE XX

20.0 GOALS/MEASURES - SYSTEM REQUIREMENTS

20.1 Goal: To adequately support the system requirements to support the NHC to allow a efficient and effective exchange of information between the plan and the Department.

20.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

The workplan should provide assurances that the plan will be Year 2000 compliant.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

20.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

20.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

ARTICLE XXI

21.0 PLAN RESPONSIBILITIES - IMPLEMENTATION ACTIVITIES AND TIMELINES

21.1 Introduction: The plan shall collaborate with the Department, and provide sufficient resources, for the development and implementation of the NHC. In order for the NHC to be operational effective July, 1999, the Department and the plan shall be prepared to work cooperatively as necessary prior to July, 1999. All requirements are described pursuant to this contract. The plan shall comply with the proposed timeline for meeting this expectation. The exact timelines may vary as the Department and plan work together to define the exact timelines for completion of each activity, based on the plan's level of "readiness."

22.0 GOALS/MEASURES - IMPLEMENTATION ACTIVITIES AND TIMELINES

22.1 Goal: To collaborate in the development and implementation to ensure programmatic readiness effective July, 1999.

22.1.1 Initial Measure: A workplan that identifies the plan's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the plan to evaluate the effectiveness of the activities.

The workplan shall include a detailed description of how these, and similar, policies and procedures will be implemented. Describe any written protocols, training and education that will be provided to staff, providers and clients.

The initial workplan shall be submitted and approved by the Department prior to July, 1999.

The plan's internal operations manual addressing the requirements shall be included with the initial workplan.

Proposed printed materials shall be included as part of the workplan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution plan.

22.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed workplan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The plan shall be required to address specific issues, problems and how the plan resolved such issues.

22.1.3 Minimum Requirement: The plan shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the plan on an ongoing basis. The plan shall demonstrate compliance with all related NHC policy and procedure. The Department will not unreasonably withhold approval, and shall work with the plan to meet this requirement.

ARTICLE XXIII

23.0 PLAN RESPONSIBILITIES - CONTRACT SUMMARY

23.1 Introduction: The following Contract Summary represents programmatic and reporting activities required by the Department for the ongoing implementation of the NHC:

1. Client Participation and Enrollment Processes;
2. Interface with the Enrollment Broker Services;
3. Plan/PCP Responsibilities in the Provision of the Basic Benefits Package;
4. Quality Assurance/Quality Improvement;
5. Client Rights and Responsibilities;
6. Systems Requirements; and
7. Implementation Activities and Timelines.

The plan shall also participate in Administrative Partnerships required by the Department to effectively implement the NHC.

The plan will be required to report on all NHC activities in a Management Report submitted by the plan to the Department on a quarterly basis.

The plan will be required to provide consistent reporting of all activities pursuant to this contract and to meet all performance goals.

23.2 Contract Processes and Responsibilities: Under the management, monitoring and direction of the Department, the following policies and procedures apply to the NHC and shall be completed in cooperation with the plan, the Enrollment Broker Services (EBS) and the Data Management contracted entities.

Client Participation and Enrollment Processes	Who's Responsible
1. Determination of Client's Managed Care Status	Department
2. Design and Maintenance of the Managed Care File	Department
3. Interface Between the Department's Eligibility System and the Managed Care File	Department
4. Providing NHC information to the client at the Initial Eligibility Interview for Medicaid	EBS/HHS Local Office
5. Obtaining Authorization for Release of Information	HHS Local Office
6. Completing Managed Care Enrollment and Documenting Enrollment Activities	EBS
7. Completing Automated Reenrollment into Managed Care	Department
8. Notifying client of enrollment into NHC	Department
9. Completing Automatic Assignment of PCP/Plan	EBS
10. Completing Client Requested Transfers	EBS

11. Completing PCP/Plan Requested Transfers & Interim PCP Assignments	PCP/Plan/EBS/ Department
12. Completing Disenrollment/Waiver of Enrollment Requests	EBS/Department
13. Coordinating Care From Acute to Custodial Levels of Nursing Facility Care	PCP/Plan/Departmen t

Enrollment Broker Services	Who's Responsible
1. Development/Distribution of Informational and Marketing Materials- Enrollment Related (General In Nature)	EBS
2. Development of Plan-Specific Enrollment Materials	Plan/EBS
3. Distribution of Plan-Specific Materials to Enrolled Clients	Plan
4. Completion of Enrollment Activities	EBS
5. Completion of Education/Outreach	EBS
6. Completion of Health Assessment and Distribution to Plan	EBS
7. Providing Public Health Nursing Staff for PCP/Plan Referrals and Coordination of Care Issues	EBS
8. Completing HEALTH CHECK (EPSDT) Outreach	EBS
9. Staffing and Documenting Helpline Activities	EBS
10. Conducting Client Satisfaction Surveys	Plan/EBS/Department
11. Performing Client Advocacy	Plan/EBS/Department
12. Completing Lock-In Procedures	EBS/Department

Basic Benefits Package	Who's Responsible
1. Providing the client a " Medical home"	PCP
2. Participating in the NHC as a Primary Care Physician	PCP
3. Enrolling as a Medicaid Provider in one of the five Specialty Areas Designated to be a PCP, maintaining all appropriate licensure, following all Medicaid requirements	PCP
4. Providing the Basic Benefits Package to the client; providing all necessary referrals, coordination of care and 24 hour availability; maintain medical records, utilizing the EBS; maintaining communication with other providers;	PCP
5. Accepting the choice of a client or the assignment by the Department to be the client's PCP	PCP
6. Requesting the client's disenrollment, or transfer according to NHC regulations	PCP
7. Following the NHC guidelines on the number of clients/PCP	Plan
8. Performing as an Interim PCP, or Specialist PCP	PCP
9. Ensuring the same level of services are provided to the managed care client as that provided to a non-managed care client, per 471 NAC; complying with all referral and prior authorization requirements, coordinating services that are not included in the Basic Benefits Package or that require additional Departmental approval; and accepting the Department's interpretation of 471 NAC.	Plan
10. Ensuring adequate PCP access/availability and that information on the Provider File is accurate	Plan
11. Utilizing Medicaid-enrolled Providers	Plan
12. Accepting the client's choice of PCP/Plan	Plan

13. Providing case management	
14. Providing appropriate informational materials and refraining from any direct marketing	Plan
15. Complying all QA/QI Requirements	Plan
16. Providing necessary reports and data	Plan
17. Providing interpreter services, and complying with all ADA requirements	Plan
18. Applying all the Plan requirements to any subcontractors	Plan
19. Complying with all contract requirements, and any other policies or procedures as required by the Department in the overall operation of the NHC	Plan
20. If an HMO, providing member services, maintaining appropriate certification and following all state and federal requirements	Plan
21. Complying with all HEALTH CHECK (EPSDT) requirements	Plan
22. If an HMO, complying with all TPR requirements	Plan
23. Complying with all regulations pertaining to family planning services, emergency services, MH/SA coordination issues, FQHCs, Tribal Clinics, and Certified Nurse Midwife Services	Plan
24. Accepting payment as defined by the Department	Plan

Quality Assurance/Quality Improvement (QA/QI)	Who's Responsible
1. Participating in the Department's QA/QI program and maintaining an internal QA/QI program	Plan
2. Ensuring that the purpose, goals, objectives and scope of the NHC program QA/QI program are met	Plan
3. Participating in the Department's Quality Assurance Committee and maintaining an internal QAC, as appropriate	Plan
4. Participating in the Department's QA Subcommittees and maintaining internal subcommittee activities as appropriate	Plan
5. Ensuring adequate and informed provider participation	Plan
6. Providing data and other information	Plan
7. Participating in the Department's Review Processes	Plan
9. Maintaining appropriate accreditation	Plan
10. Submitting encounter data	Plan
11. Complying with all reporting requirements	Plan
12. Complying with all performance measures	Plan

Rights and Responsibilities	Who's Responsible
1. Informing the client and provider about his/her rights and responsibilities	Plan
2. Providing a grievance/appeals process for clients and providers	Plan
3. Ensuring system advocacy	Plan
4. Ensuring cultural sensitivity and diversity	Plan

System Requirements	Who's Responsible
1. Developing and maintaining the Enrollment System and ensuring an accurate interface with the HHS Eligibility System	Department/EBS
2. Issuing the Enrollment Notices	Department

3. Entering Information into the Enrollment System	EBS
4. Issuing Client Notices and other forms of Medicaid-Eligibility Verification	Department
5. Developing and Maintaining the Enrollment File and Provider File Systems	Department/Plan
6. Developing and Maintaining Payment Systems	Department/Plan
7. Coordinating Data Management and Reporting with the Medstat Group	Department
8. Maintaining appropriate technological capabilities	Plan

Implementation Activities and Timelines	Who's Responsible
1. Providing necessary resources for the development and implementation of the NHC	Plan
2. Ensuring an adequate provider network	Plan
3. Developing educational/marketing materials	Plan
4. Developing system-related technologies	Plan
5. Provide training to staff/providers	Plan

23.3 Quarterly Management Report: The plan shall be required to comply with all programmatic and contractual requirements of the NHC. To ensure uniform and consistent reporting of the plan activities, the Department shall require each plan to submit a management report of all related activities each quarter. The quarterly report will allow the plan to report on all NHC requirements pursuant to this contract. The Department shall utilize the information in the quarterly report to monitor compliance and for reporting NHC performance.

The plan shall state the general requirement, summarize the plan's activities for each requirement, quantify outcomes and provide appropriate documentation. The plan may also utilize the report to raise issues/concerns, etc.

The management report will be due forty-five days after the end of each quarter:

July, August, September	Due November 15
October, November, December	Due February 15
January, February, March	Due May 15
April, May, June	Due August 15

The management report shall provide the Department a summation of the plan's activities, along with appropriate, i.e., reports, contract deliverables, etc., to substantiate the plan's performance.

The report shall be evaluated on the following basis:

Met is defined as follows: The response shows a thorough understanding of the requirement and demonstrates ability to meet or exceed the requirement on an ongoing basis. The response must comply with minimum standards as defined by Department staff.

Unmet is defined as follows: The response is below an acceptable level and does not demonstrate an understanding of the requirement or an ability to bring the response into compliance. Any response that is judged to be Unmet will be justified in writing to the plan and the plan will be allowed to take corrective action.

The Department will develop a NHC report each quarter describing the program's progress for the previous quarter, based on the information submitted by the plan and other similar sources. The final report shall be completed by no later than thirty (30) calendar days after receipt of the report. The completed report shall be shared with the plan, HHS officials, and HCFA-KCRO.

First Quarter Status Report	Completed by December 15
Second Quarter Status Report	Completed by March 15
Third Quarter Status Report	Completed by June 15
Fourth Quarter Status Report	Completed by September 15

As appropriate, the plan may state "No Change" . As long as the plan meets the reporting requirements pursuant to this contract, and any amendments or other NHC directives, the report will be considered complete. If the Department reviews the report and finds any deficiencies or areas that require additional information or clarification, the Department shall communicate this to the plan in writing. Any necessary corrective action shall be taken.

To the extent possible, the Department has attempted to accurately represent all current policies and procedures applicable to the NHC. The plan shall be required to cooperate with the Department and state and federal regulations, as well as participate in continuing efforts to improve the NHC program, required revisions and modifications to existing programmatic and systematic requirements.

23.4 Report Format: The report shall address, but is not limited to, the following:

1. Client Participation and Enrollment Processes

- A. Cultural Diversity/Sensitivity Awareness
- B. Transition into NHC
- C. Client Movement/Continuity of Care
- D. Client Eligibility/Mandatory NHC Participation/Enrollment Issues
- E. NHC Paper Processes
- F. Enrollment-Related Education & Outreach Materials/ Departmental Review/Marketing Criteria
- G. Pregnancy-Related Services
- H. Client/Client Advocacy
- I. Managed Care Verification (Notices, NMES, etc.)
- J. Enrollment File Layout/Processing
- K. Hospitalization
- L. Auto-Assignment
- M. Transfers
- N. Nursing Facility Admission/Discharge

2. Interface with Enrollment Broker Services

- A. Plan-Specific Marketing Materials/Departmental Review/Marketing CriteriaB. Health Assessment and Protocols
- C. Public Health Nursing
- D. HEALTHCHECK (EPSDT)
- E. Helpline
- F. Client Advocacy/Coordination with EBS
- G. Lock-In Procedures

3. The Basic Benefits Package-Provider Specific:

A. Provider Network
B. Client Access/Provider Location & Demographics
C. Operationalizing the Client's "Medical Home"
D. Teaching Facilities
E. Claims Payment/Client Billing
F. Specialist as a PCP
G. Physician Qualifications
H. Enrollment Limitation
I. Provider Education
J. Interim PCP Procedures
K. PCP Fraud/Abuse Issues

The Basic Benefits Package-Plan Specific:

A. Contract Performance Goals
B. Plan Materials
C. Reporting
D. Physician Incentive Program
E. Use of State Laboratories
F. Interpreters/Client Accommodations
G. ADA Requirements
H. Member Services
I. Case Management
J. Coordination with EBS
K. Advance Directives
L. Discrimination
M. Provision/Interpretation of the Basic Benefits Package
N. HEALTHCHECK (EPSDT)
O. Third Party Resource
P. Coordination of "Excluded" Services
Q. Coordination with MH/SA Services
R. FQHCs, Rural Health Clinics, etc.
S. NCQA Accreditation
T. Professional Liability Issues
U. Client/Provider Complaints/Grievances

4. Rights and Responsibilities

A. Client Rights and Responsibilities
B. Provider Rights and Responsibilities
C. Complaint/Grievances
D. System Advocacy
E. Cultural Diversity/Sensitivity

5. Quality Assurance/Quality Improvement

A. Quality Assurance Committee
B. Quality Assurance Subcommittees
C. Utilization Management
D. Credentialling
E. Member Advocacy and Education
F. Preventative Health
G. Medical Records
H. Provider Participation
I. Data and Information Sources
J. Review Process/Levels of Concern/Corrective Action
K. Quality Improvement Process
L. Plan Review

M. Accreditation
O. Submission/Use of Encounter Data
P. Reporting
Q. Performance Measures

6. System Requirements

A. Enrollment-Related
B. Provider File
C. Enrollment Report
D. Claims/Payment-Related
E. Encounter Data

7. Implementation Activities and Timelines

A. Development/Implementation

23.5 Adhoc Reporting: The Department may request the plan to provide information or participate in presentations to the following and other, such groups:

(a) Legislative Study Groups and Hearing Committees;

(b) HHS Policy Cabinet; and

(c) Public Health Grants and Special Contracts.

23.6 Problem Resolution and Communication: The Department may request the plan to participate in the following cooperative efforts, as deemed appropriate by the Department:

(a) Client and Provider Focus Groups: Focus Groups are utilized as a way to solicit input from, and share information with, clients and providers participating in the NHC. To the degree possible, the Department requires the plan to have a representative at all client and provider meetings. Additionally, the plan may be asked to assist the Department in organizing and hosting the meetings, inviting client members to attend, assisting with transportation needs, etc.

(b) Vendor Meetings: The Vendor Meetings are held monthly and are utilized for the purposes of information-sharing, policy clarification and issues resolution. Representatives with program/management responsibility and authority from the plan, the EBS and the Department are required to attend each meeting.

(c) Work Groups: As policy and procedure issues are identified, representatives from the plan, the EBS and the Department meet on an adhoc basis to resolve them. Workgroup activities are reported at the monthly vendor meetings. Departmental policy, procedures and Contractual language are revised as appropriate.

(d) Key Contacts-Issue Specific: The plan shall provide a list of key staff to provide immediate contact on specific issues. At a minimum, the following areas require the plan and the Department to identify key contacts:

(1) Case Management/Member Services
(2) Systems-Related: Provider File
Enrollment Report

Encounter Data

(3) General Policy/Procedures
(4) Other: Marketing
QA/QI
Provider Relations
Benefits Coverage/Authorization
Provider Enrollment
Payment/Billing/Claims Payment
Complaints/Grievances

(d) Oral/Written Communication: If points of discussion result in a change or clarification to the overall NHC program, the Department shall issue a policy memorandum, revise NAC regulations and complete amendments to the contract, as necessary.

DEPARTMENT OF HEALTH AND HUMAN SERVICES SYSTEM FINANCE AND SUPPORT

By_____
Jeff Elliott, Director

Dated this _____ day of _____, 1999

By_____
Cecile A. Brady
Interim Medicaid Administrator

Dated this _____ day of _____, 1999

_____
Federal Taxpayer Identification

EXCLUSIVE HEALTHCARE, INC.

By

_____, (Position)

Dated this _____ day of _____, 1999

R9169A